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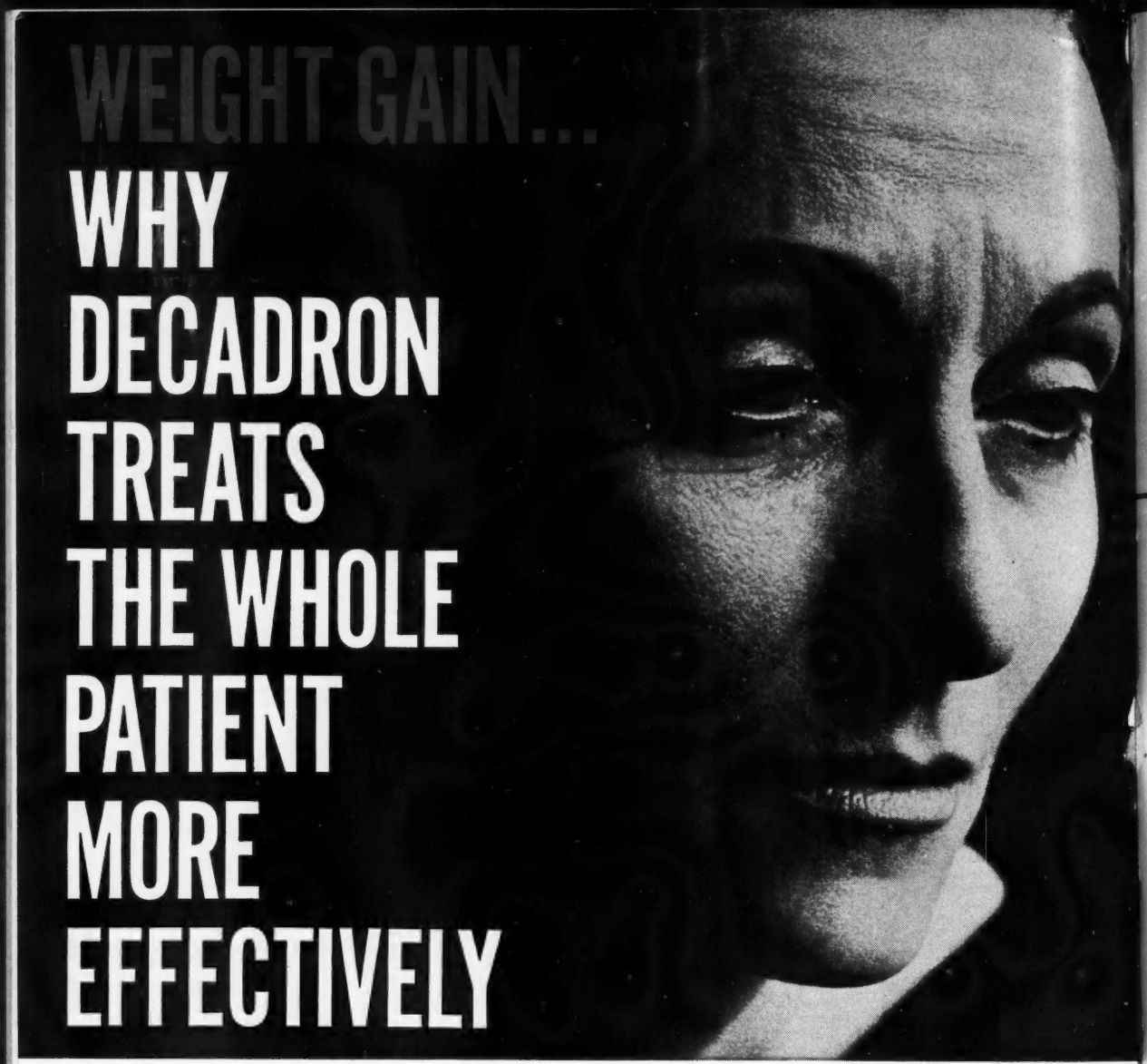

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California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

Volume 92 MAY 1960 Number 5

The Coroner and the Common Law

I. Introduction

JESSE L. CARR, *M.D.*, San Francisco

ONE OF THE STATUTES of the State of California (Section 27491 of the California Government Code) declares, "It shall be the duty of the coroner to investigate, or cause to be investigated, the cause of death of any person reported to the coroner as having been killed by violence, or who has suddenly died under such circumstances as to afford a reasonable ground to suspect that his death has been occasioned by the act of another by criminal means, or who has committed suicide."

In addition to this basic statement, there is much more to this section of the California Government Code. It establishes the manner in which the investigations may be conducted, and it outlines the powers of the coroner in the effective pursuit of his duties. Together with similar sections of the codes of the several counties, it further authorizes and defines the coroner's official activities.

While this codification of the duties of the coroner is relatively new in California,* the office itself and the statutory authorization to inquest are among the most ancient of English common laws, from which many of ours are derived. The office of coroner is so old, in fact, that the actual date of its beginning is unknown, but it is one of the many old Saxon institutions which were adopted by the Normans after their conquest of England and so found their way into the English statute books.

Regardless of the date of its origin, the office of coroner is one of the few remaining offices in the modern scheme of things that has persisted with little change both in England and in much of America since the English colonists arrived in this country carrying with them many legal precepts of the old country. The original title *custos placitorium coronal* (keeper or guardian of the crown) was eventually corrupted to "cornaus," then through various transitions became "coronator," "crowner," and finally in the fourteenth century, "coroner." The coroner was an officer of the crown and he was one of the first of the king's legal assistants.

As early as 925, the office of coroner is mentioned in the Athelstan Charter to Beverly. This was an honorable office, and none but a lawful and discreet knight was chosen as crowner. The founding of the office and its investment with authority were in part due to the anxiety of the people over the increasing powers of the sheriffs. The coroner was required to keep an exact record of the pleas of the crown, thus obtaining the duties of recorder. He was charged in addition with the responsibility of confiscating revenues due the king by the forfeiture of chattels belonging to felons, and as such was a collector of internal revenue. He inquired into all felonies. In

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Part I of an article in five parts. Others will appear in succeeding issues.

*The Coroner's Act was passed by the California Legislature in 1876.

instances where homes had been feloniously entered and violated he was required to "proceed immediately" to the scene of the entry and conduct an investigation of the robbery. In this capacity he assumed certain police powers. The coroner had the major burden among the king's officers of bringing criminals to justice, and consequently was known as a conservator of the peace. At one time in English history he was required to inquire concerning "treasure trove" and to report his findings to the king. He heard accusations and appeals from accusations of rape, examined wounds and investigated mayhem. He pronounced judgment upon outlaws and in this capacity became an advocate. He was empowered to pursue persons (besides the principal culprits) who had foreknowledge and had not given warning in cases of murder or burglary.

The coroner was responsible for carrying out regulations concerning deodands—that is to say, the things or chattels that caused death by misadventure, such as an ox that killed a man. It was the duty of the coroner to seize the deodand and have it or its monetary value forfeited to the king. If a man were drowned at sea an entire vessel might be forfeited. As late as 1838, a coroner's jury levied a deodand forfeiture of 1,500 pounds on the boiler of the S.S. *Victoria*, which had exploded and caused a loss of life. These forfeitures were generally bestowed upon the church for the good of the soul of the persons deceased, in the manner of alms. This legal principle and its legal sequence of conviction and indemnification represent the beginning of our present system of industrial compensation.

The coroner was also required, on behalf of the crown, to seize all the goods and chattels of those who were found guilty of suicide—suicide at that time being a felonious crime. In certain circumstances he was also concerned with other fiscal rights of the crown and at times performed part of the duties of tax collector.

Although charged by law with these numerous duties, many coroners of the day devoted the major portion of their attention to securing profit for the crown rather than searching for the truth in felonious matters or inquiring into the mechanisms of violence and causes of unexplained deaths. With the passage of time and for various reasons the office of coroner lost much of its power. Accumulated experience led to a clearer definition of the duties of the various officers of the king, and many of the duties of the coroner were delegated to other agencies. With police responsibilities expanding as society became more complex, a more elaborate scheme of law enforcement was developed and the police powers of the coroner declined, except where the office was combined with that of sheriff. Tax collecting became a specific, distinct and increasingly important necessity, for which a separate office was established. Many of the other miscellaneous functions of the coroner's office were also assumed by other existing bureaus or newly developed departments.

The judicial functions of the coroner were eliminated by the adoption of the Magna Charta in 1215, the abrogating clause stating, "No sheriff, constable, coroner, or other of our bailiffs shall hold pleas of our Crown." The statute De Officio Coronarius (for Edw. I, Statute II) redefined the coroner's powers and duties; and although later repealed, this statute forms the basis for our modern laws regulating the coroner's responsibilities. The office may still be, and often is, combined with that of sheriff of the same county, or with that of public administrator. In such a dual role, the coroner retains much of his historic importance, for he may simultaneously assume the responsibilities of all three offices. It is also, perhaps, of interest to remember that in his singular capacity the coroner is still the only state or county official who has the power to arrest the sheriff.

As originally established after the Magna Charta, the coroner's office had both the power of inquest and the power of investigation. With the evolution of more modern systems of legal investigation and law enforcement, the investigating powers of the coroner's office were assumed by the police, and the coroner was reduced to the single duty of holding an inquest, which was only a fact-finding procedure. He was without other authority either judicial or punitive and his findings were not admissible as evidence in a superior court of law. The many limitations reduced the coroner's office to so low a level of responsibility that it lost much of its public dignity and esteem. It became obvious that the office could not function effectively without the power of inquiry, and in 1926 the powers of investigation were reconferred upon the coroner in the United States. From this time to the present there has been a gradually expanding, and recently a rapidly growing, recognition of the importance of the functions of the office of coroner, or medical examiner.

Throughout the past centuries repeated studies of the coroner's office have been made and the qualifications of the coroner have been recurrently evaluated. Innumerable investigators and fact-finding boards have made reports and recommendations. There has been general accord in these reports that the relationship of the coroner to the public should be clarified—in some respects specifically altered—and that the facilities of the office should be further developed and improved. Because of the similarity of the legal systems in England and in the United States, the many expressions of dissatisfaction with the structure and stature of the office and the urge

to investigate the problems have had not only a long historical background but a wide international basis. In 1825, Thomas Wakeley, then the editor of a London newspaper, bitterly opposed the system of appointing attorneys, undertakers and ignorant laymen to coronerships. Like many reformers, he felt that he would make a good incumbent, and he did. He was elected to the office of coroner in 1839 after spending a fortune during the preceding 14 years of electioneering. He was 23 years in office, constantly fighting for reform and improvement. It was through his efforts that the coroner in England customarily is a practitioner of medicine.

English legal tradition has a strong influence upon the American system and, following this early example, Philadelphia in 1839 elected a doctor of medicine to hold the office of coroner—the first physician-coroner in the United States. Although such enlightened precepts were transmitted from the mother country to our eastern seaboard rapidly, their extension to the rest of the country was remarkably slow. Even at this writing only ten states of our fifty have statutes that make the degree Doctor of Medicine a prerequisite to holding the office of coroner. Since that day in 1839 in Philadelphia, which is one of outstanding importance in medicolegal history, repeated investigations have reported and described the weaknesses of our coroner's system and made recommendations for correction. Unfortunately, as is the case with so many investigations, good or bad, the reported context has had little influence on public officials, on legislators or on their constituency, the public.

Three states have taken action after receiving the recommendations of their respective study groups. In 1877 a medical examiner system was established in Massachusetts by a law which provided that medicolegal examinations of each county should be done by "able and discreet men, learned in the science of medicine." The act also stipulated that they be appointed for a period of seven years by the governor of the state and that their investigations were to be concerned with the "dead bodies of such persons only as are supposed to have come to their deaths by violence." An autopsy was to be performed by the medical examiner when "it was authorized in writing by the District Attorney, Mayor, or Selectman of the district." In 1915, the legislature of the State of New York established the office of Chief Medical Examiner in New York City. According to the act, he and his assistants had not only to be doctors of medicine, but trained pathologists as well. The chief medical examiner was to compete for his office in free and open examination, the successful candidate being appointed by the mayor for life. He, in turn, was to have the privilege of appointing his assistants. The constituency of Iowa, in 1959, after the state legislature eliminated the coroner's office there, instituted a statewide medical examiner system.

Even with this extraordinary example of progress in these instances, the office of coroner generally deteriorated elsewhere. In 1926, a survey was made by Raymond Moley into the coroner's system of the State of Missouri, a state that does not require the coroner to be a physician. (Missouri serves as an example only because of the specificity of the Moley investigation.) Moley found among the men holding the office of coroner in the State of Missouri music dealers, candy makers, farmers and a number of other persons of widely diversified talents and sometimes dubious occupations. Most commonly he found that the office of coroner was held by a mortician who sought the position because, as coroner, he often had privileged information, early contact with the families of deceased persons, and jurisdiction over the body in question. He had a place to keep it and, by virtue of possession, he had a competitive advantage over others in his business. Far from being an exception, the State of Missouri is typical of the majority of states. Moley found that the office of coroner was losing, or had lost, much of its dignity and influence. This was in part due to the lack of requirement that persons who might accede to the office must have special knowledge—this despite the extraordinary powers which the coroner might have. Conduct in office of many incumbents also at times degraded the reputation of the office. With such decline in public esteem it was often difficult to enlist good candidates for the office. There have been instances in which no candidate appeared for election unless the office was combined with that of sheriff, which carried more authority and the right to collect fees, or with that of public administrator, wherein the elected official had an opportunity to acquire accessory income by administering estates for a percentage.

Until recently, academic interest in medicolegal problems has been meager. In only specific areas have offices been given enough financial and moral support to attract well trained and competent candidates.

The American Medical Association in 1943 directed a special investigation into the procedure, administration and accomplishments of the current medicolegal systems, but neither their investigation nor the passing of 17 years since the Moley investigation produced much that was new. In 1944, when the report was published, it contained the conclusion that throughout most of our country legal medicine was used less effectively in the administration of justice than in any comparable country in the world.

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Rheumatoid Arthritis

Current Therapy and Medical Management

ALBERT J. JOSSELSON, *M.D.*, Alhambra

• **Although no routinely effective therapy for patients with rheumatoid arthritis is available, certain established principles of management and a variety of medications do provide benefit.**

Conservative management programs may suffice in milder cases. Aspirin or other salicylates and physical therapy are the mainstays in such programs.

The antimalarial drugs may be helpful in a small proportion of cases. Steroids have had beneficial effect rather consistently and, with the newer analogues, certain side effects have become less troublesome. The usual precautions with the use of these compounds must be observed as always. Chrysotherapy remains important in the treatment of severe cases, and its use should not be postponed until major destructive joint changes have occurred.

RHEUMATOID ARTHRITIS is a disease characterized by spontaneously occurring remissions and exacerbations. A variety of factors may produce alterations in the course of the disease but exactly what they are and how they function remains unknown. Because of the fluctuations both in the degree of joint inflammation and in the extent of concomitant constitutional reaction, evaluation of any treatment program is extremely difficult. However, observations made on large numbers of patients over the course of many years of treatment have established the value of several therapeutic agents as well as certain principles of management. The advent of commercially available steroids ten years ago marked a major therapeutic advance. Chrysotherapy had been available for some 20 years before that. Whether or not the appearance of the antimalarial agents has provided any real additional assistance remains subject to some question.

Each introduction of a new steroid in the past few years has been heralded as the long awaited panacea for all rheumatoid arthritis. As experience with the newer analogues has accumulated, it has become apparent that the physiologic but undesirable side effects characterizing the earlier drugs have remained. Certain notable exceptions include the lessened or minimal mineralocorticoid effects of the delta 1 steroids, methyl prednisolone, triamcinolone and dexamethasone, and the diminished gluconeogenic effects of dexamethasone. The usual care in the selection of patients and precautions in administration of these agents must be exercised as always.

The purpose of this paper is to discuss a realistic program of medical management for patients with rheumatoid arthritis of varying degrees of severity and to evaluate some factors of importance in the selection of an appropriate program.

There is no specific treatment or cure for rheumatoid arthritis. Even if there were, the principles of management in a conservative program of treatment would remain of prime importance. Preservation of joint function, decrease of inflammation, and prevention, wherever possible, of permanent destructive changes are the basic goals.

Presented as part of a Panel Discussion on Present-Day Management of Rheumatoid Arthritis before the Section on Physical Medicine at the 89th Annual Session of the California Medical Association, San Francisco, February 21 to 24, 1960.

Many patients with early or mild disease may have a favorable response to a conservative regimen of management. Whether or not the natural course of the disease is altered by such a program cannot be proven statistically.[11] It has been observed that even with excellent steroidal suppression of local articular symptoms as well as constitutional manifestations, radiographic evidence of increasing joint damage will appear on films taken at intervals.[4] However, suppression of active synovitis with concomitant relief of pain and muscle spasm permits a more effective rehabilitation program. Frequently, restoration of degrees of self sufficiency and occupational activity are achieved which would otherwise be impossible.

For patients with early mild rheumatoid arthritis or for those in whom the disease has shown a tendency toward occasional spontaneous remissions, a so-called conservative program of management may be entirely sufficient. Decrease in joint inflammation and prevention of joint deformities generally can be achieved in at least 50 per cent of patients. The incidence of remissions or major improvement has been variously reported as from 48 to 71 per cent of patients treated conservatively.[3,10,12] Features to be emphasized to the patient in a conservative program include: extra rest, avoidance of abuse to involved joints, a well rounded nutritious diet with vitamin supplement, salicylates as required for analgesia, and a physical therapy program including heat, massage and exercise.

The amount of rest must be determined by the severity of joint involvement. In mild cases, routine nocturnal bed rest plus an extra two or three hours daily may suffice. In patients with severe involvement and much constitutional reaction, a period of total bed rest may be required. Abusive activity must be carefully avoided. Prolonged weight-bearing may perpetuate the inflammatory reaction present in a knee or an ankle. Sometimes it may be necessary to alter or change completely a patient's occupational activity. For example, a carpenter by continuing at his trade may make it impossible to control the involvement of a wrist joint.

No proof has ever been presented that any food or group of foods alters the course of rheumatoid arthritis. Because some patients do present problems of inadequate food intake, empirically a well balanced diet is recommended. A multiple vitamin supplement also is advised for similar reasons, and *not* because any vitamin lack can cause or any vitamin addition can cure rheumatoid arthritis.

Salicylates remain one of the most important drugs in any treatment program. In addition to excellent analgesic effect, aspirin appears to have some suppressive action on the synovitis, although by what means is unknown. The drug should be given to tolerance; 0.6 to 0.9 gm. (10 to 15 grains) four times a day is the suggested minimum. Administration with meals or the use of enteric coated or buffered tablets generally will minimize gastric distress. Mild toxicity may be manifest by tinnitus or diminished auditory acuity. With the latter, the dosage should be reduced to prevent possible permanent deafness. With severe toxicity, reduction of prothrombin activity may result in bleeding tendencies, necessitating immediate lowering of dosage. Acute toxicity of severe salicylism may be manifest by mental confusion, drowsiness and hyperpnea. These symptoms demand immediate discontinuance of the drug.

The value of physical therapy cannot be overemphasized in any treatment program for patients with rheumatoid arthritis. Adequate treatment and careful instruction in a home program to be followed by the patient should be provided by the physiatrist, but it remains the responsibility of the supervising clinician to see that the patient faithfully follows the program. Modifications and new techniques should be introduced as needed.[9] Too often this portion of the patient's program is neglected or omitted altogether. Hill and Holbrook[6] estimated that not one patient in a hundred follows a proper schedule to protect his joints and maintain function.

Large numbers of rheumatoid patients have been treated with Butazolidin® with varying degrees of success. Fear of toxicity[8] has limited my experience with this compound. Frequency and severity of side effects have apparently diminished significantly since the dose given for maintenance has been reduced to 400 mg. or less daily.

Because of ease of administration, antimalarial preparations may be used in milder cases of rheumatoid disease. These may be given a ten or twelve week trial, using either chloroquine or hydroxychloroquine, known commercially as Aralan® or Plaquenil®. The average dose of Aralan® is 250 mg. a day and of Plaquenil® 200 mg. a day. These doses are given in single tablets, preferably after the evening meal.

Side effects, which occur in about 25 per cent of patients, consist principally of gastrointestinal distress such as nausea, cramps or diarrhea, skin rashes, headache or blurred vision. If such symptoms occur, the dose may be temporarily reduced or omitted. Administration of the drugs may sometimes be resumed without recurrence of the undesirable effects after the symptoms of toxicity have cleared.

Because leukopenia and anemia have been reported in rare instances, it is wise to have a complete blood cell count done soon after the beginning of treatment and then at intervals of a few weeks in the next several months. In my experience, the incidence of good response to the chloroquine group of drugs has not been as high as that reported by other investigators; I have noted favorable results in only 30 to 40 per cent of patients.

If the patient's status is not sufficiently improved after a reasonable trial period with a conservative program, the addition of an oral steroid may be indicated. Steroids should not be used as a substitute for a conservative regimen but rather should serve as an addition to it in properly selected cases. Careful history-taking and physical examination are mandatory for every candidate for steroid therapy. Important contraindications to use of steroids include active, latent or questionably healed tuberculosis, peptic ulcer, history of psychotic episodes, significant azotemia or renal insufficiency, ocular herpes, acute disseminate bacterial infections or acute thrombophlebitis. With the newer steroids with less mineralocorticoid activity, hypertension and congestive cardiac failure are less strongly contraindicative. Diabetic patients receiving dexamethasone in dosages up to 3.0 mg. daily have had generally only modest increases in insulin requirements.[7]

Clinical experience with the newer steroids has been amassed rapidly and several hundred scientific papers dealing with the use of them have already appeared. With all steroids proven to have significant anti-arthritic activity, certain substituents on

the cycloperhydrophenanthrene nucleus are essential: An oxygen atom at the 3 position, a double bond between carbon atoms 4 and 5, an oxygen atom or hydroxyl group on C11, an hydroxyl group at C17 and a ketone group on C20. Considerable alteration in effects on salt and water metabolism can be produced by the placement of additional substituents, notably a halogen at the 9 alpha position. Much of this effect can be negated by the addition of an hydroxyl group at the 16th carbon position (triamcinolone) or a methyl group at this position (dexamethasone). At the same time a significant portion of the enhanced anti-inflammatory effect is retained.

Dosages of the following steroids are considered to be equipotent respectively in their anti-inflammatory effects: cortisone 30 mg., hydrocortisone 25 mg., prednisone or prednisolone 5 mg., methyl prednisolone or triamcinolone 4 mg., and dexamethasone 0.75 mg. Very little basic work has been done to explain how these compounds bring about an anti-inflammatory or antirheumatic effect. As a matter of fact, no explanation is forthcoming regarding the reasons for potentiation produced by substituents added at various positions. Whether augmentation is produced by intrinsic effects related to the added atom or radical or whether structural additions simply interfere with the degradation of the compound or the formation of its conjugates by the liver, remains unknown.

Orally administered steroids should be given in divided doses, preferably after meals and at bedtime. There is little justification for adhering to a strict six-hour schedule, for apart from interfering with the patient's rest, it entails greater risk of peptic ulceration. Boland and Headley[2] reported on the value of preparations combining steroids with antacids.

Aside from peptic ulcer, other undesirable side effects of long continued use of steroids include facial rounding and hypertrichosis, cervicodorsal hump, mental stimulation, insomnia, acne, weakness and fatigue. These difficulties generally clear readily as the dosage of the drug is reduced or eliminated. More serious side effects include peptic ulcer, fractures, mental changes, periarteritis nodosa and overwhelming intercurrent infection. Hazards of long-term prednisone therapy increase alarmingly when the daily dosage exceeds 15 mg.[1] A safe long-term schedule of treatment probably should not exceed 10 mg. of prednisone daily (or comparable amounts of the other steroids) and lesser dosages should be used for adolescents and postmenopausal women.

If contraindications to the use of steroids exist or if response is not satisfactory, chrysotherapy should be considered. Although its use is empirical, gold may have a suppressive effect upon rheumatoid activity. It is a mistake to postpone the use of gold salts until major destruction of a joint has occurred and then to employ it as a last resort. Gold cannot restore damaged cartilage or bone, nor can it produce any favorable effects on inactive rheumatoid arthritis.[5] Gold may check further progress only in active disease, and the clinician should make it clear to the patient that previous destructive changes are irreversible. The patient should be apprised also of the potential toxicity of this compound and the need for careful supervision throughout the period of its administration. The patient should also be aware of the fact that favorable results are obtained only in about two-thirds of persons treated. Previous serious toxicity to gold and acute lupus erythematosus are contraindications to its use. Serious liver or renal damage and blood dyscrasias render gold therapy more hazardous than it might otherwise be.

Mild toxic reactions to gold may be observed in about 40 per cent of patients. More serious reactions are observed in somewhat less than 5 per cent. Before each injection, the patient should be questioned or examined for symptoms or signs of stomatitis, gastritis, colitis or dermatitis. Other possible toxic manifestations include nephritis, hepatitis, blood or bone marrow disturbances, including anemia, leukopenia, agranulocytosis or thrombocytopenia. Regular examination of blood and urine is mandatory.

Toxic reactions generally are well controlled with the use of BAL (British anti-Lewisite) or steroids. Furthermore, in some cases gold therapy may be continued despite a skin rash, cramps or diarrhea if these symptoms subside after careful adjustment of the dosage.

A schedule I have found useful, using a soluble gold salt, is to commence with a dose of 10 mg. and then give it twice weekly in gradually increasing amounts until the total dose at each injection is 50 mg. This amount then may be administered at weekly intervals until optimal response has been obtained; usually this will require from 600 to 1,200 mg. Thereafter the interval between doses may be cautiously lengthened to two, three or four weeks, the weekly schedule being resumed if an exacerbation occurs. If a monthly maintenance dose adequately suppresses recurrences, it may be continued for a year or longer until all joint disease appears to be suppressed. Too rapid discontinuance of gold nearly always results in an exacerbation of the arthritis.

It is apparent that no ideal treatment exists for this chronic and unpredictable disease. Much has been done but much more remains to be done, particularly in the investigation of possible modes of action of the steroid group of drugs.

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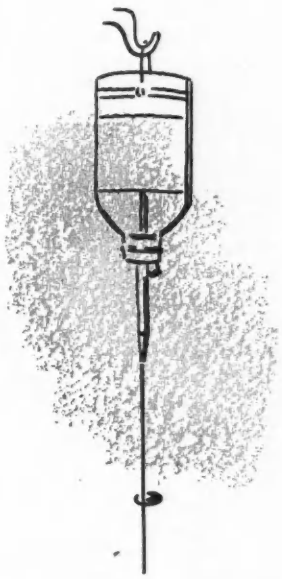

Rheumatoid Arthritis

Present-Day Physical Therapy

FRANCES BAKER, *M.D.*, San Mateo

• **Physical therapy is an important therapeutic agent for patients with rheumatoid arthritis. Well directed exercise balanced with rest is fundamental. Careful muscular reeducation is as important in the treatment of patients with arthritis as it is in caring for a patient with paralysis. Pain with slight malalignment and limitation in the joint will cause muscles to lose their sequence of action and so upset the rhythm of motion.**

Active exercise with a balanced use of assistance and resistance to movement, combined, as indicated, with traction upon the joint or stretching of constricted tissues may result in (1) stabilization of the joint, (2) increase in range of movement, (3) relaxation of antagonists, and (4) reduction of atrophy. The objectives of muscular exercise then are (1) reduction of pain, spasm and deformity, (2) development of muscular power, and (3) restoration of the normal rhythm of movement.

IT IS GENERALLY STATED that some 25 per cent of patients with rheumatoid arthritis get well or recover sufficiently with minimal care; that 10 per cent have what may be called a malignant form of arthritis, become very ill, have pronounced destruction of joints, and fail to respond to any treatment. Between these two groups are some 65 per cent of patients who require close supervision. For them, satisfactory therapeutic planning should result in adequate rehabilitation.

It is well to keep in mind that rheumatoid arthritis is a generalized disease with involvement of joints a conspicuous feature, that the cause is unknown, that the course is long, that the duration of the active process cannot be estimated, but that this process does come to an end eventually. In such circumstances the treatment must be planned on a long-time basis, and this is something that the patient must understand. The confidence of the patient must be gained at the outset. The patient is often depressed because of the pain and limitation of performance which excludes him from his ordinary association with his family and from his routine social activities. This means that the family must understand the situation sufficiently to provide the necessary kindness balanced with toughness which will render the best support in the home. Treatment must be continuous, simple and practical. It consists of rest, both mental and physical, necessary analgesics, physical therapy and, at times, splinting. Many patients require certain more or less specific drugs, such as the steroids or gold. Manipulative or surgical treatment may be required if deformities are permitted to develop.

Physical therapy is recognized as having a most important place in the treatment of arthritis. The musculoskeletal system should receive attention from the time the patient first presents himself for care, whether this be at the onset of the disease or at any stage in its development. The aim is to relieve pain, to combat atrophy, to retain normal mobility, to prevent or reduce deformity, and so to rehabilitate the patient to the limits of possibility. The physical therapeutic modalities used are heat, massage and exercise, but there is considerable variation in the manner in which these are applied. Careful consideration must be given to the state of the patient and to selection of the treatment that will result in the best response. Numerous articles have been written to show that physical therapy can be carried on in the home. Various forms of heat are prescribed and programs of exercise are outlined and taught the patient in a relatively brief time, either in the hospital or in the clinic. Fortunately, a few investigators have discussed the advantages of long-time care in institutions. Wyman[16] mentioned the spas of Europe and the better mental and physical rest that can be obtained in a hospital equipped to take care of chronic disease than in the home. Emotional shock, worry and anxiety are better controlled. Better arrangements can be made for the severely crippled patient who must start walking. Duthie[6] wrote: "All are agreed on the importance of local and general rest during the active phases of the disease, the prevention and correction of deformity by splints, and the restoration of function by physiotherapy and graduated exercises. However, the application of these measures is rendered exceedingly difficult in practice by lack of accommodation in hospital, adverse social and economic circumstances in individual patients and, perhaps more important, a dearth of physicians with adequate training and ex-

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perience prepared to devote a substantial proportion of their time and energies to the study and care of these patients."

Duthie described a study made in Great Britain, in which over three hundred patients were observed. Treatment consisted of bed rest in hospital an average of nine plus weeks, good positioning, maintenance exercises, correct handling and treatment of joints, such drugs as aspirin, codeine and iron, at times transfusions, and balanced diet. When maximum improvement had been attained, the patient was sent home on a well planned regime. Of 307 patients, 281 were followed, 100 of them showing an advance of one grade in functional capacity and 70 an advance of two or more grades. Treatment in hospital also had a significant effect in reducing the activity of the disease, which was assessed by the sedimentation rate, hemoglobin level and objective signs of inflammation in the joints.

There are economic and social barriers and we know that it is impossible to keep large numbers of arthritic patients long in hospital. We do not have the proper facilities, nor can the patient afford such service. Since physical therapy is very important, patients cannot be left to their own devices in carrying out programs in the home. Well supervised physical therapy is a necessity. It must be carried on in the clinic or office while adequate arrangement for rest and proper activity in the home is planned and a member of the family is being trained to assist with the physical therapeutic measures. This means a compromise but it does not underrate the need for satisfactory treatment individually planned.

The rationale for physical therapy must depend first upon an understanding of the pathologic delineations of the disease as a whole, and secondarily upon anatomic and physiologic knowledge of the function of involved joints and tissues.[1]

Heat

Heat causes a definite increase in circulation due to vasodilatation, and it reduces pain by counterirritation. These are both reflex effects of the heat acting upon the nerve endings in the subcutaneous tissue, reflex vasodilatation and cutaneovisceral reflexes. Relaxation of spastic muscles may occur secondarily. It is believed that a rise of temperature within muscles accelerates the chemical processes of the cell fiber, thus affecting the viscous and elastic properties of the contractual tissue to increase the amount of work without changing the energy required. Cold, of course, causes vasoconstriction but as the constriction is immediately followed by vasodilatation the final response is little different from that to be expected from elevating the temperature of the tissues. For the most part, elevation of the temperature either locally or generally gives greater comfort.

Massage

Massage has a limited value in the treatment of arthritis. It can assist in moving the increased fluids following vasodilatation. Light stroking acts upon the sensory nerve-endings to reduce pain. It can be used directly over joints. Deep stroking and kneading to muscles releases tension and improves circulation. Massage in no way replaces exercise since it cannot produce any of the metabolic changes produced by contracting muscles.

Exercise

Exercise, when used correctly, is by far the most important agent in the treatment of arthritis. Passive exercise or so-called relaxed movement has no real place in this program. Active exercise, on the other hand, has definite and important physiological effects on skeletal muscle. It stimulates circulation, maintains or increases flexibility and reduces atrophy. Furthermore, exercise promotes a sense of generalized well-being which is probably the result of not only direct action by the muscles but indirect action of physiological bodily responses. These responses are in reasonable proportion to the amount of work done. Work may be minimal when pain is severe and assistance is required to move the joint; but work may be increased by applying gradually increasing resistance to the movement. Active exercise with a balanced use of assistance and resistance to movement combined with traction upon the joint or stretching of the soft tissues as indicated may result in (1) stabilization of the joint, (2) increase in range of movement, (3) relaxation of antagonists, (4) reduction of atrophy. Thus, the objectives of muscular exercise are to reduce pain, spasm and deformity, to increase muscular power and to restore normal rhythm of movement.

Careful muscular reeducation is as important in the treatment of patients with arthritis as it is when caring for a patient with paralysis. It often becomes more difficult, for pain and even slight malalignment and tightness in the joints will cause muscles to lose their proper sequence of action and upset the rhythm of movement. Manual assistance rather than mechanical equipment should be employed. A properly instructed therapist can train, guide, assist, resist, exert traction and stretch, thus directing joints into line and muscles into rhythmic action. Mechanical apparatus must be used with caution until the patient is trained and fair power is developed. However, as arthritis becomes quiescent, general exercise with and without apparatus can increase muscular power and hence endurance, lead to a feeling of well-being, and possibly return patients to useful work in spite of the handicap of deformed and severely damaged joints.

A patient who is very ill with acute rheumatoid

arthritis (as indicated by pronounced synovitis, elevated temperature, severe pain and spasm of muscles) requires bed rest. Acutely painful joints must be splinted. Some observers believe that the splints must be fixed and non-removable. Preston[13] and Kuhns[11] recommended that the splints be worn constantly when motion is very painful, and later only at night, that they be discarded when inflammation subsides, that only after the acute inflammation is subsiding should exercise of the part and use in the activities of daily living be instituted in order to preserve function. Preston said that "fixed contractures, intraarticular scars or erosions of articular surfaces do not usually develop in joints during the acute or subacute stages of the disease so that normal musculoskeletal function may be restored in most instances by corrective exercises after the acute inflammatory pathology subsides and the joint can be moved without pain." It has been observed that when this situation presents itself, a carefully made plaster splint which can be removed to permit the use of either ice packs or moist heat followed by very gentle manual traction and assisted resisted motion within the limits of pain, will consistently reduce the amount of muscular spasm and will make the care of the joint much more simple than is possible when it is placed in a nonremovable splint. When casts have been in place for two or three weeks, motion is difficult to obtain and the fear of the patient is greatly increased.

Routinely we see what can be classed as the subacute or chronic condition where limitation of motion exists and where deformities may be present in various stages. Every joint in the body must be examined and adequately treated. The entire spine[8] must be kept mobilized and posture maintained. The rib cage must, if at all possible, continue to move upon the spine at the costovertebral junctions to preserve good intrathoracic space and function. Care of certain joints can be considered in more detail.

The Hand

In spite of the fact that the hands are of greatest importance in the economic world, and that every individual depends upon his hands for independence, they have not received the attention that we would like to see in the treatment of arthritis. Fortunately, interest has been increasing. The hand[5] is used in "gripping," "pinching," and "tapping." All of these functions require flexion at the metacarpophalangeal joints with varying amounts of flexion at the interphalangeal joints. Pinching, of course, requires flexion of the metacarpophalangeal joints with extension of the interphalangeal joints and approximation of thumb to fingertips. Since the normal position of the relaxed hand is one of flexion with moderate ulnar deviation at the metacarpophalangeal joints, it is not uncommon to find this position becoming fixed, with secondary hyperextension at the proximal interphalangeal joints and flexion at the distal interphalangeal joints. Contracture of soft tissues, including the intrinsic muscles, is bound to occur and deformity results. At this point the wrist may tend to palmar flexion due to overactivity of the long flexors. The wrist must keep moderate dorsiflexion to permit a strong grasp.

The aponeurosis of the metacarpophalangeal joint with its control by the extensor digitorum communis is of vital importance in maintaining the function of the hand. In the hand in particular, joints often are hyperflexible due to changes in the fibrous tissue. Frequently this is an early sign of arthritic disease. Severe synovitis with the increased synovial fluid can so stretch the capsule with its ligaments that the joint loses stability and subluxation results. The program of exercise for the hand is planned with regard to the aponeurosis and the rhythmic action of the muscles. Complete extension of the metacarpophalangeal joints is the starting position for all the fundamental movements of the digits. Complete extension of the first joint must be obtained so that the dorsal aponeurosis is drawn proximally before the intrinsic muscles can, through their attachment to it, extend interphalangeal joints correctly. Full extension of this first joint is necessary to permit the proper direction of pull on the aponeurosis and the first phalanx by the intrinsic muscles to bring about lateral motion of the digits. The long flexors require extension of the first joint to obtain full flexion of the interphalangeal joints before the aponeurosis is relaxed and the intrinsic muscles pull the metacarpophalangeal joint into flexion to permit a firm grasp. Bunnell[4] said that all intrinsic muscles act in the flexion of the metacarpophalangeal joints. Perry[12] noted that electromyographic studies revealed no action of the interosseus when the metacarpophalangeal joints are flexed. This movement is entirely due to the lumbricales. Further study of this point would seem necessary. However, it does not change the rhythm of functional movement, which is: extend the first joint, then the second and third; flex the second and third, and then flex the first.

Training in this rhythm of movement can prevent deformity before it has had time to occur. If the fixation has not become static, improvement of range can be gained by stretching the shortened soft tissues to permit realignment of joints. If the deformity is pronounced and the tendons of the extensor digitorum communis have swung lateralward across the metacarpal heads, correction cannot be obtained by this kind of stretching, but power is improved by it and pain therefore relieved to such

an extent as to make the hand much more useful. At the same time abduction and opposition of the thumb must be obtained or preserved.

The Wrist

Tenosynovitis of the long flexors as they cross the wrist can limit both extension and flexion of the fingers. Full active or passive extension of the wrist and fingers can prevent this development. A syndrome of particular importance is that of spontaneous rupture of the long extensor tendons of the wrist.[7] Destruction of the radioulnar articular disc with consequent subluxation of the ulna predisposes to this lesion. It is believed that the subluxated ulna impinges upon the tendons and compression is increased by the tension of the dorsal carpal ligament. Physical therapy used to increase the range of function may play a part in causing this condition. Since it is important to maintain motion, prophylactic excision of the ulnar styloid may be indicated in appropriate cases. Such a measure would not only avoid rupture of extensor tendons, but would greatly improve pronation and supination. It is important to note subluxation of the ulna and to try to protect the tendons against rupture.

The Knee

In the lower or weight-bearing extremity, perhaps the knee is the key joint. The hips are involved less frequently. Flexor contractures of the hip are secondary to those of the knee. Prevention of contractures at the knee is most important. Sufficient rest, proper splinting, simple manual traction or stretching with assisted and resisted motion, particularly for extension, should protect the knee. Extension is most easily and painlessly obtained when the patient is lying supine with the hip in extension at the edge of the table. The quadriceps femoris is working at its best advantage since it is, in part, a two-joint muscle and resistance to extension can be applied most satisfactorily. When traction is required, the knee can be flexed and the pull placed just distal to the knee, against the tibia, in an attempt to transfer the tibia distally before attempting to extend it upon the femur. Where contractures have occurred, manipulation under anesthesia is frequently of value. Often the adhesions give easily and extension can be obtained without great force. If it cannot be obtained by this means, then operation is indicated rather than use of a wedged cast.[14] Wedging is slow and often painful, which often discourages the patient. Also, unless the progress of wedging is watched very carefully, the hamstrings may cause subluxation of the tibia upon the femur.

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Lobar Pneumonia

The Distribution of Sites in Infants and Children

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• **In a review of roentgenograms of 228 pediatric patients with segmental pneumonia, the left upper lobe was observed to be involved in only 4 per cent of cases. The right upper lobe was involved most frequently—over eight times as often as the left upper lobe and twice as often as the right middle or lower lobe. It is suggested that this distribution is related to the fact that the angle of the left bronchus in relation to the median plane is more acute than the angle of the right bronchus, the sharper angle perhaps serving as protection against aspiration.**

FOR MANY YEARS certain facts regarding the distribution of segmental and "lobar" pneumonia in infants and children have been recognized—(1) that involvement of the right upper lobe predominates, and (2) that localized inflammatory disease on the left is largely confined to the lower lobe. It was the purpose of this investigation to ascertain if these facts still hold, and to attempt to establish the reason for this distribution.

Segmental pneumonia as referred to in this discussion is limited to homogeneous infiltration of one of the bronchopulmonary segments, according to the Jackson-Huber classification. Involvement of all the segments of one lobe was infrequently demonstrated. Interstitial pneumonia and bronchopneumonia are excluded.

From San Francisco General Hospital, San Francisco 10.
Submitted April 17, 1959.

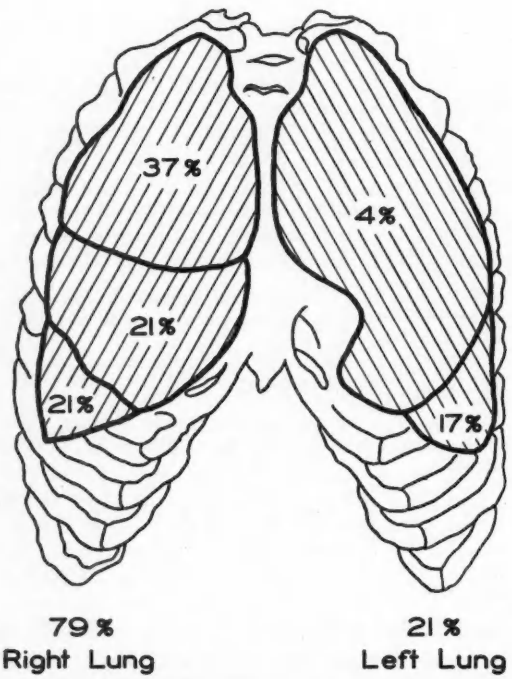

Figure 1.—Distribution of pneumonia in 228 infants and children observed at San Francisco General Hospital in a five-year period.

The material was gathered by reviewing roentgen studies of 285 patients cross-indexed as having segmental pneumonia from the records of the University of California and Stanford University pediatric services at the San Francisco General Hospital for the period 1952-1957. Two hundred and twenty-eight cases were selected as having fulfilled the criteria for this study.

In agreement with previous observation, the data in the present series (Table 1 and Figure 1) showed a preponderance of right lung involvement—79 per cent against 21 per cent. It was also observed that segmental pneumonic disease occurred in the right upper lobe eight times as often as in the left upper lobe.

On the right, nearly half of segmental pneumonic involvement was located in the upper lobe and about one-fourth each in the middle and lower.

Although the left upper lobe was involved in ten cases, if the lingula is considered the middle lobe

TABLE 1.—*Lobar Distribution of Pneumonia in Infants and Children Through Age 14, University of California and Stanford Pediatric Services, San Francisco General Hospital, 1952-1957*

Site Involved	No. of Patients	Per Cent of Series	
Right upper lobe	85	37	79 per cent right lung
Right middle lobe	47	21	
Right lower lobe	47	21	
Left upper lobe	10	4	21 per cent left lung
Left lower lobe	39	17	
	228	100	

counterpart of the left lung, there were only four cases of true left upper lobe involvement, or an incidence of less than 2 per cent. Neither the anterior segment of the left upper lobe nor the apical portion of the apical-posterior segment of the left upper lobe was involved. Nine of the ten cases of upper left lobe involvement occurred in Negro or Latin-American patients, but this is not considered of clinical significance, since most of the pediatric patients at San Francisco General Hospital fall in this category.

DISCUSSION

At birth, the bifurcation of the trachea lies at the level of the third thoracic vertebra, then gradually descends to the level of the fifth vertebral body at age ten and there remains until old age, when it may go still lower (sixth thoracic body). It is thought that the increase in the angle of the upper lobe bronchi with the saggital plane produced by the descent of the bifurcation provides a protective mechanism against upper lobe pneumonia in adults, since it lessens the possibility of aspiration to these segments. The larger diameter and more vertical direction of the right main bronchus are probably other factors accounting for the greater frequency of right lung pneumonia.

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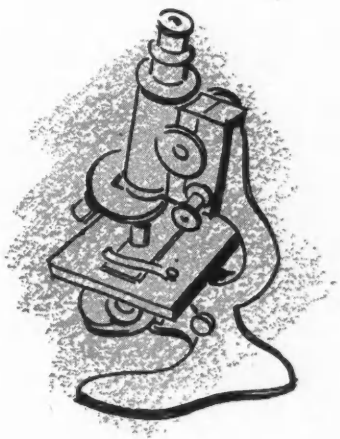

The Psychodynamics of Hypertension

CHARLES WILLIAM WAHL, *M.D.*, Los Angeles

• **Psychotherapeutic study of patients with essential hypertension shows evidence of massive repression of unacceptable feelings in many areas of the personality, predominantly feelings of rage and hostility. It appears that in the mentation of the hypertensive person, rage not only risks the loss of affection and approval by others, but is unconsciously equated by him with murderous loss of self-control. In addition, he characteristically has an inordinate fear of death.**

Intensive insight psychotherapy, when commenced early in a well-motivated patient, is very effective in the treatment of this disorder. As in any psychosomatic condition, the patient should be concomitantly treated by his general physician or by an internist.

WE ARE ALL familiar with the expressions, "Watch your blood pressure"; "Don't get your blood pressure up"; "Don't burst a blood vessel," applied to persons who are in the process of becoming angry or enraged; or again, "apoplectic with rage"; "flushed with anger"; "the veins stood out on his neck like cords." The import of all of these idiomatic expressions of folk knowledge is that rage, especially suppressed rage, has something to do with an increased blood pressure. And the composite of the psychic structure of the hypertensive patient, as obtained from psychotherapeutic scrutiny, amply seconds and supports this folk view.

The typical patient, with essential hypertension, as delineated by psychotherapeutic study, shows an external friendliness, blandiloquence and excellent self-control, beneath which there are powerful feelings of hostility, rage and anxiety. Latent repressed hostility is found in every neurosis, but the difference as noted in hypertension is that the emotions of rage are exceedingly intense, chronic, inhibited, repressed, not expressed in motility or adequately bound in any organized neurosis. The patients also are generally not able to satisfy passive dependent wishes or gratify hostile ones, and hence remain blocked in both directions. They have a "double bind" conflict here—they are "damned if they do, and damned if they don't."

Why does the person with hypertension have more of a problem in handling his rage than most of us? There is a variety of evidence suggesting that the repression of hostility is so massive because the patient's early experience of hostile rage, manifested either in thought or deed, became equated with murderous loss of self-control. From dreams and other sources we know that in unconscious mentation a thought is equated with the deed and is equally culpable with it. Hence the patient feels the same anxiety and guilt over fantasied acts of aggression as he might experience with completed ones. This basic unconscious pattern, which is learned very early, is transferred and perpetuated in all later competitive striving, such as in work, the achievement of social position, prestige, etc., so that success in these activities is also equated with murderous annihilation. Paradoxically, as success mounts, the individual has to work all the harder to keep rein on his hostile aggressive impulses and the guilt and terror attendant thereupon.

But important as the repression of hostility is in the genesis and progression of this illness, there is no convincing evidence that this factor is uniquely specific. Hypertension is known to be caused by fear, anger, sexual excitement, and sustained exertion and striving. If conscious, these states are appropriate and self-limiting, but if unconsciously repressed they are perpetual and enduring. Clinically, all these factors may be encountered in hypertension, singly and in combination, with repression of hostility the dominant though not the exclusive repression.

However, the early background of these patients casts a particular light on the genesis of these circular and mutual reinforcing neurotic mechanisms. In many such studies there has been found, as an outstanding feature of the antecedent environment, a profound sense of early insecurity in relation to primary familial figures. Death of a parent or separation from one occurred as a prevenient factor in over half of one such group.[1] In 23 of a group of 24 patients studied in the same group, serious hypertension was first observed after such emotional disturbance as severe illness of a relative, injury, illness or other trauma to the patient, changes in the patient's life, such as separation, divorce, illness of a child, loss of a job, or loss of savings—circumstances which recapitulated an earlier and unresolved traumatic conflict. In 13 of 24 the emotional disturb-

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ances seemed to be mainly a reaction to serious illness or death of a close relative.

In the author's experience these patients also characteristically show, both consciously and unconsciously, an inordinate fear of death; and from dream and other evidence it seems clear that they feel that their death must follow as a consequence of antecedent death wishes toward their ambivalently regarded love objects. The history of incipient essential hypertension is closely related and similar to that of early psychoneurosis: headache, dizziness, tinnitus, excessive fatigue, and mood changes are prominently described and are often out of proportion to the extent of physical disease that is present.

The role which intrapsychic factors play in the genesis of hypertension was further elucidated by Schulz and Schwab,[3] who found the incidence of hypertension in the American southern Negro to be two and one-half times that in whites. Kesilman,[2] in a survey conducted in a northern prison, found hypertension three times as common among Negroes as among whites; and since the African Negro is, of all peoples, the most free from this disease, it would appear that the singular pressures of life for the Negro in our culture have a relationship to this high incidence. The author has heard from a physician recently returned from Johannesburg that the clinics there in which urban Negroes are treated encounter a very high incidence of malignant hypertension, a disease unknown in the tribal populations.

The exact physiological mechanisms are not known whereby a persistent and unalleviated state of tension, stress and repressed rage produces the organic changes which may later become irreversible in hypertension. Wolf[4] and co-workers have reported evidence of renal vasoconstriction and ischemia in response to experimentally produced psychological stress: When conflictful and unpleasant matters were introduced into conversation with their subjects, the renal blood flow was reduced by as much as 25 per cent from the control level. It would be most interesting to know whether this process is intermittent or continuous in these patients and whether it causes the renal pressure phenomena which are now being so extensively studied.

As for psychotherapeutic measures, it is easy to see that if the rage and anxiety that are so conspicuously repressed are due to unconscious reasons, then counseling, support, reassurance, exhortation and advice to the patient to express his hostility more openly will be futile—and so it proves to be. No hypertensive patient was ever cured by being advised to beat his wife or talk back to the boss.

The consistent experience of the author and of other investigators is that intensive insight psychotherapy, if begun before irreversible organic change has taken place, with a motivated patient and by a psychiatrist adequately trained and experienced in this work, is almost always successful in alleviating or vastly modifying the illness. Since this process may involve anywhere from 50 to 350 hours of work, obviously no psychiatrist has a large series, but the general experience is that successfully treated patients remain normotensive, feel generally better and cope more successfully with a wide variety of life stresses, since the goal of successful psychotherapy is to resolve not only the presenting complaints but any concomitant neurotic difficulties.

It is important, however, that the patient be referred for psychotherapy early, before irreversible damage has occurred, and that the referring physician work conjointly with the psychiatrist in the medical management of the patient. This is the custom in psychiatry for two reasons: first, because the well-trained psychiatrist by the time his training is finished, is usually a decade away from his own intensive medical training and not generally competent to supply the quality of medical care which his colleagues can; second, because it is technically difficult to function at once as both psychotherapist and internist.

This whole area of the joint study and treatment of psychosomatic disorders such as hypertension has only begun to be explored. No greater opportunities exist for an expansion of the frontiers of medical understanding.

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The Use of the Abbott-Rawson Tube

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• **The Abbott-Rawson tube is a useful device in gastrointestinal surgery, as it obviates intravenous and intramuscular therapy. Jejunal rather than intravenous feedings may be used and the tube may also be used for administration of potassium, antibiotics and vitamins.**

ALTHOUGH MANY USES beyond that for which it was first employed have been developed for the Abbott-Rawson tube, it remains a much neglected surgical adjunct. For a time after it was described in 1937, the device was widely used for the emptying of the gastrointestinal tract at times of surgical stress. Now it is described in only one textbook on surgery.[1] Yet there are a number of collateral advantages—in nutrition and in administration of drugs, fluids and electrolytes—to having the tube in place. Among them is the prompt jejunal feeding of debilitated patients after operation. Nutrition with carbohydrates, proteins and fats impossible to administer intravenously, can be carried out. Potassium deficiencies are easier to deal with. The danger of overloading the circulatory system with fluids, which is a hazard to be reckoned with particularly in older patients when fluids are infused by vein, can be avoided. A further use of the tube is for introduction of antibiotics and vitamins into the gastrointestinal tract rather than intramuscularly.

The following case is illustrative.

A 41-year-old laborer was admitted to hospital with a history typical of intractable duodenal ulcer of three months' duration. A double-lumen Abbott-Rawson tube was introduced the night before operation. The tube was first passed through the nose and brought out through the mouth. There the metal jejunal bulb was attached to it, and the bulb was swallowed. The stomach was then irrigated with 500 cc. of sterile dilute hydrochloric acid solution. At operation a standard antecolic, isoperistaltic, gastrojejunostomy with subtotal gastrectomy was performed. Before the gastrojejunostomy was completed the distal feeding tube was inserted into the distal jejunal loop.

After the operation, 100 cc. of 5 per cent glucose in saline solution or water was given every eight hours by slow drip into the tube. Erythromycin and vitamins B and C were added to the fluid. On the fourth day, the tube was removed and the patient was permitted to take liquids by mouth. On the seventh postoperative day he was discharged from the hospital and recovered without complications.

We have used this tube in 28 consecutive cases. The usual criteria are used in determining the length of time the tube remains in place and the amount and kinds of fluid delivered. In four of the patients, additional intravenous therapy was carried out for the first 24 hours postoperatively to overcome pronounced dehydration and electrolytic imbalances. In three cases mucus and blood plugged the tube and a Levine plastic tube had to be inserted to aspirate the material from the stomach. The jejunal feedings, however, were continued. It is believed that once the nurses are trained in the use of the tube, plugging can be prevented. Constant irrigation is necessary. Erosion at the suture line appeared not to be a hazard in the present series, nor could we find a report of such occurrence in the literature.

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Submitted November 13, 1959.

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Acute Epiglottitis

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• **Although acute epiglottitis is not a rare disease and may be very severe or fatal, it is one not familiar, as it should be, to all physicians dealing with children.**

Diagnosis may be confirmed clinically by direct or indirect examination of the epiglottis. Vaporized cool water is preferable to steam for reducing the swelling of mucosal tissues that impairs breathing.

Chloramphenicol is the drug of choice, as the majority of cases of acute epiglottitis are due to H. Influenzae.

Tracheotomy must be carried out if necessary to maintain an airway.

MANY PHYSICIANS are but little aware of acute epiglottitis as a potentially serious and sometimes fatal disease of infants and children. Although the condition was recognized at the turn of the century, only in the last five years has it been included as a distinct entity in pediatric textbooks.[1,2]

Acute epiglottitis is not a rare disease. Miller[7] said that at one hospital about one case a month is observed. Berenberg and Kevy[2] reported on 42 patients with the disease observed in an eight-year period, only one of whom was referred to the hospital with the correct diagnosis. In light of these facts, it behooves physicians who may be called upon to attend children to become better acquainted with this disease and to be prepared to treat it as an emergency.

REPORT OF A CASE

A six-year-old boy was admitted to the U.C.L.A. Medical Center with acute upper respiratory tract obstruction. He had been well until the morning before admission, when he complained of sore throat and anorexia. The body temperature gradually rose. At 2 o'clock in the afternoon the patient was examined by a physician who noted mild pharyngitis and fever and prescribed a tetracycline preparation.

That evening at 8 o'clock difficulty in breathing became apparent and when the physician observed him the patient was sitting up in bed, drooling and having moderate inspiratory stridor. The alae nasae flared, and suprasternal, intercostal and lower sternal retractions were prominent. The epiglottis, easily visualized by depressing the tongue with a tongue blade, was decidedly inflamed and edematous.

Upon arrival at the hospital, the patient was given chloramphenicol intramuscularly and cold steam inhalations were started. When his condition did not improve in two hours, tracheotomy was done. Breathing immediately became easier and by the following morning the patient was afebrile and had no respiratory distress. Chloramphenicol was continued by mouth and the tracheotomy tube was removed after four days. He was discharged on the fifth day. The leukocyte content of the blood at the time of admittance to hospital was 26,900 per cu. mm.—69 per cent neutrophils, 13 per cent banded forms and 15 per cent lymphocytes. No significant organisms grew on cultures of the blood and material from the throat, trachea and epiglottis.

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Etiology

Hemophilus influenza, type B, has been generally considered to be the causative agent in acute epiglottitis. This organism has been the most common one recovered from the throat and from the blood of patients with this disease, although other bacteria have grown on cultures in some instances.

Some investigators[1] believe that this disease, along with most infections of the respiratory tract, is brought about by some precursor disease, most commonly a viral infection, with secondary complications caused by organisms which may be present in the respiratory tract at the time.

Clinical Manifestations

This condition usually affects children between two and six years of age and commonly occurs in the late fall, winter and early spring. Camps[5] reported four cases in infants under one year of age. A very interesting case in a 12-year-old, considered to have bulbar poliomyelitis, was reported by Gundell.[6] Brewer and Rambo[3] have reported cases in adults.

The onset of the disease is abrupt, fever and sore throat being the prominent findings. A younger child may merely gag when drinking. Early in the course of the condition the pharynx is mildly hyperemic and some of the anterior cervical lymph nodes slightly tender. Dyspnea may or may not be

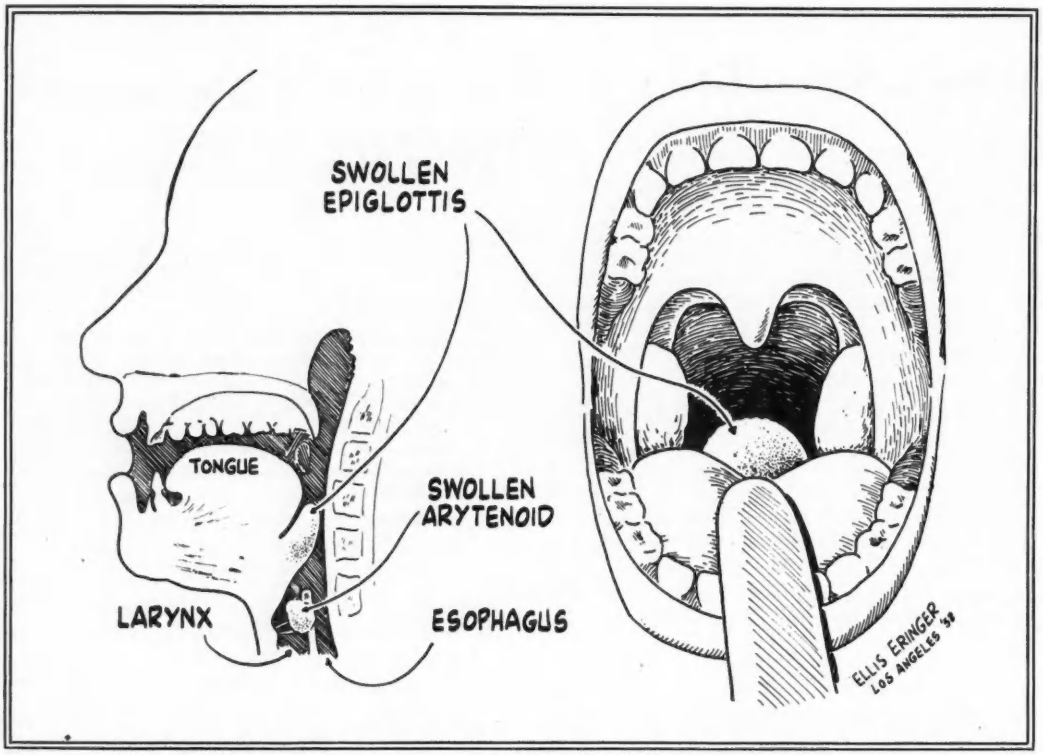

Figure 1.—Showing the swollen arytenoids and epiglottis, and the position of the epiglottis as it appears to view when the tongue is pressed down with a blade.

observed early. Any child with soreness of the throat greater than seems consistent with the visible condition should be considered as possibly having acute epiglottitis.

Pronounced dyspnea, pallor, cyanosis and prostration ensue in a few hours, and by that time there is usually no question about the diagnosis. Inspiratory stridor with pronounced suprasternal and infrasternal retraction occurs. The patient sits up, leans forward, gasps for air with his mouth opened wide and his tongue protruding, and drools excessively. There is a muffled quality to the voice rather than the hoarseness seen with other laryngitides. The pulse and respiration rates are sharply accelerated.

Usually the diagnosis can be confirmed simply by looking at the epiglottis, which can be exposed to view by depressing the tongue or by pulling the tongue forward. In most children, the mere placing of the blade on the tongue will cause the swollen, reddened epiglottis to rise into sight. For an older child, a mirror may be needed for visualization.

From the pathological viewpoint, probably a better name for this disease would be supraglottic laryngitis or supraglottitis. Inflammation and swelling is usually confined to the epiglottis, the aryepiglottis folds and arytenoids. Some superficial ulceration of the mucosa may be present. Cultures of the blood or of material from the epiglottis and pharynx may grow H. Influenzae or other significant organisms.

Differential Diagnosis

Spasmodic croup, one of the diseases to be differentiated from acute epiglottitis, may be preceded by mild upper respiratory tract symptoms or none at all. There may be slight temperature elevation, and typical barking cough is usually present. The epiglottis is not swollen or red as it is in epiglottitis. Spasmodic croup usually responds quickly to increasing the humidity of inspired air.

In acute laryngitis, involvement of the vocal cords is evidenced by definite hoarseness. There may be little dyspnea at the onset. Aphonia should suggest the possibility of diphtheritic laryngitis.

Acute laryngotracheobronchitis is usually slower in onset than acute epiglottitis, symptoms referrable to the respiratory tract usually not developing until after a day or two of illness; and when respiratory difficulty does develop, usually there is expiratory as well as inspiratory impairment, as

against inspiratory only in epiglottitis. Rales may be heard in laryngotracheobronchitis but usually not in epiglottitis.

Treatment

Early establishment of an adequate airway is the primary consideration in dealing with a patient with acute epiglottitis. There are few times in medicine when a disease may require more exacting or immediate treatment. When the respiratory obstruction is not so profound as to require immediate by-passing of the upper respiratory passages, increasing the humidity of inspired air helps reduce the swelling of mucosal tissues, vaporized cold water being superior to steam for this purpose. The apparatus for producing it consists of a nebulizer through which water may be forced by compressed air or oxygen with the nozzle placed close enough to the patient to permit large quantities of the cool vapor to reach respiratory passages.

Chemotherapy should be started at once—chloramphenicol given intramuscularly in dosages of 100 mg. per kilogram of body weight per 24 hours for children up to 15 kg. and 1 to 2 gm. per 24 hours for children over 15 kg. The daily dose is administered in three equal injections at eight-hour intervals. After one day of therapy, the drug may be given orally at a dosage of 50 mg. per kilogram of body weight per 24 hours.

When the patient has pronounced suprasternal and intercostal indrawing, or the pulse is increasing at the rate of ten per hour, or the respiratory rate is increasing, tracheotomy is mandatory. Passing an endotracheal tube is not desirable because of the preexisting inflammatory and edematous condition, except as a preliminary measure until a tracheotomy can be performed. Tracheotomy is preferably performed in the operating room under general anesthesia after an endotracheal tube is passed. Occasionally a temporary laryngeal obstruction may develop in the induction phase, but with the proper equipment at hand the passage of an endotracheal tube is not a major problem.

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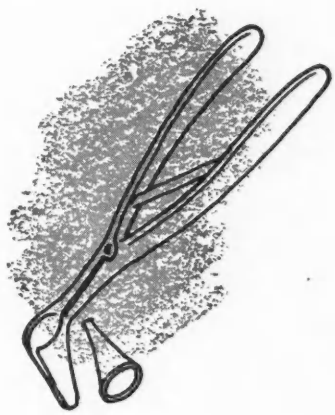

A Technique for Hernia Repair

JOSEPH BRISBANE, *M.D.*, Beverly Hills

• **After Ryan reported a low recurrence rate in a large series of patients with recurrent inguinal and femoral hernia who were operated upon by a technique developed by Shouldice and later improved, an adaptation of the method was used in a number of difficult cases. In the dissection technique, the transversalis fascia is completely transected from the internal ring to the pubic spine. This exposes a fascial layer which has never before been described as being intentionally used in hernia repair. The method of imbrication with steel wire for suturing also differs from the methods most often used. Use of local anesthesia is another important part of the technique as a whole.**

In 1953 Ryan[7] reported successful repair in 369 cases of recurrent inguinal and femoral hernias, with a recurrence rate of 0.8 per cent; and in 1956[8] he reported repair of indirect sliding inguinal hernia in 313 patients, with a recurrence rate of 1.2 per cent. Compared with other published results, these are outstanding. The technique that was used by Ryan was developed by Shouldice,[9] and it has been improved by him and by others in the past 18 years. Up to the present, hernia repair, mainly inguinal, has been done in more than 30,000 cases. Some 87 per cent of the patients were observed for varying periods—mostly 5 to 10 years—after operation and in them the overall recurrence rate was 0.75 per cent.

After reading the foregoing reports, I carried out repair of hernia in a number of cases, using the method they used. The majority of cases were of a generally difficult order: The patients were obese, or they had had recurrent herniation, or the tissues were poor and the defects large.

The improved and relatively different technique of hernia repair that was used has never been described in the literature. First I would like to emphasize that local anesthesia be used, not only because it is by far the safest and almost without complications, but because it permits repair without tension on tissue, a cardinal precept in surgical operation. As the nerves that are blocked in the operative area are sensory in distribution, the only relaxation is that of a patient lying comfortably on his back. Local anesthesia is particularly desirable in the technique herein described for the stainless steel wire that is used is likely to cut through tissue if pulled too tight. Moreover, the patient can walk about immediately after operation, which gives him confidence in the repair and no reluctance to breathe deeply and cough freely.

The usual groin incision is made down to external oblique fascia. The opening should be adequate for good exposure (Figures 1 and 2) which is particularly important in dealing with obese patients and those with large defects who often have need of repair superior and lateral to the internal ring. The external oblique fascia is incised somewhat more medial than the skin incision in order to make a lateral leaf which is useful in making the subsequent repair. In this procedure meticulous hemostasis and sharp delineation of tissue planes are of utmost importance. Next, the cord is freed and the cremasteric muscle, the blood vessels it contains and the

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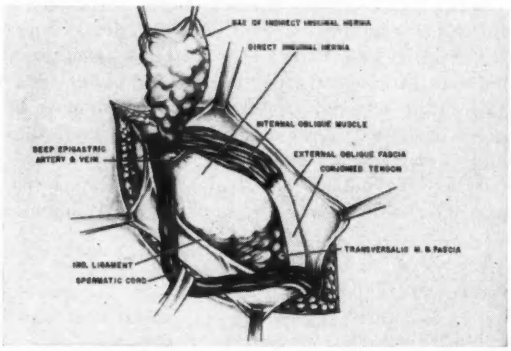

Figure 1.—Groin incision.

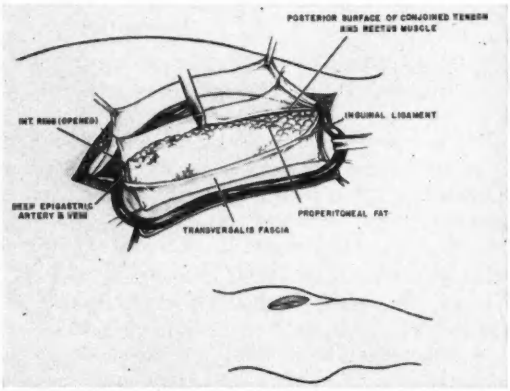

Figure 2.—The transversalis fascia, opened from pubic spine to internal ring.

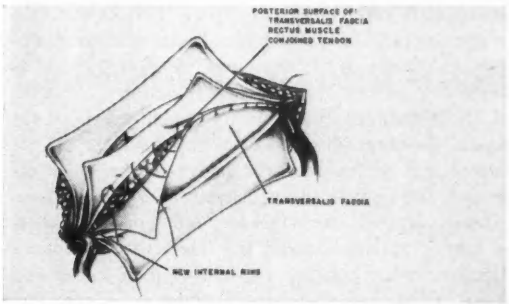

Figure 3.—First layer of stitches forming a new internal ring.

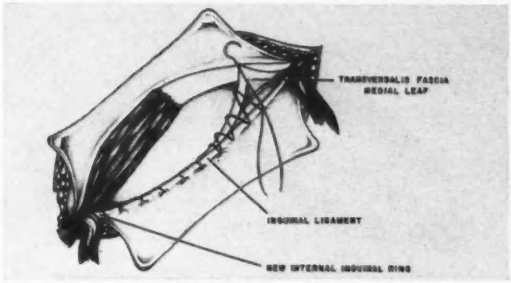

Figure 4.—Poupart's ligament engaged in second layer of stitches.

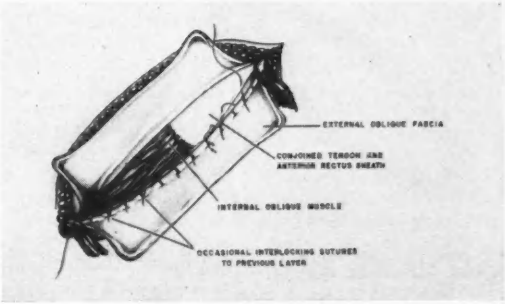

Figure 5.—Placement of third layer of stitches.

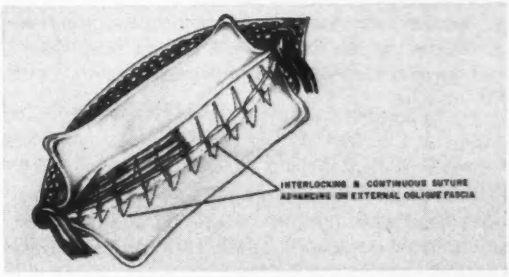

Figure 6.—The third layer is carried down to the pubis, then back for the fourth layer, interlocking with the third.

genital branch of the genitofemoral nerve are excised, along with all fat tabs, leaving a thinned out cord of vas deferens, artery and vein. With this done, if an indirect sac of peritoneum is present it may be dissected easily: The sac is opened, freed completely from transversalis fascia, ligated proximally, and the tied off portion excised. If there is no indirect hernia, peritoneum is always seen; and it is similarly freed from the transversalis fascia and muscle which form the internal ring. The floor of the canal is palpated through the internal ring and if any defect in it is noted it is opened in its entirety down to the pubic spine. At the same time the region lateral to the internal ring is examined by digital palpation and is incised if bulging. This necessitates the formation of a new internal ring. In addition, if the lower portion of the conjoined tendon is attenuated, it too is cut. With good exposure obtained by retraction of tissue, and the ilioinguinal nerve held out of the way in the direction in which it falls, the repair is begun.

A strand of monofilament, No. 34 stainless steel wire 30 inches long, threaded on a No. 5 half circle Mayo needle, is used. The inferior or lateral border of the transversalis fascia, just above the pubic spine, is approximated to the under surface of the conjoined tendon in some cases, and in others to the under surface of the lateral border of the rectus muscle (Figure 3). Choice between these two points of attachment is determined by the anatomic structure and the degree of pathological change in the individual patient. After the first stitch has been tied, a running suture is carried superiorly, the first layer being laid down with stitches 6 to 7 mm. apart until a new internal ring has been formed. This should permit easy entrance of the tip of a large Kelly clamp. The second layer (Figure 4) is continued back without tying, but engaging Poupart's ligament laterally, and transversalis fascia, transversalis muscle and internal oblique muscle medially. Again, depending on the anatomic structure and the nature of pathologic change, approximation of fascia to fascia is always sought first. At no time is tension put on the suture line, an assistant surgeon or a surgical nurse holding the loop of wire extended to prevent kinking. When fascia and periosteum at the pubic spine is reached, it is included and the first and second layers are tied. A third layer (Figure 5) is begun at the internal ring, the suturing advancing laterally along external oblique and medially along internal oblique and/or rectus sheath, the needle at the same time picking up available wire loops of the previous layer to form a partial latticework.[3,5] This third layer is carried down to the pubis and then back in a similar fourth layer (Figure 6), being tied at the internal ring. The cord is then laid on this strong floor of four interlacing wire layers, and the medial leaf of external oblique fascia, which has not been engaged in the lattice, is brought over it, the imbrication being

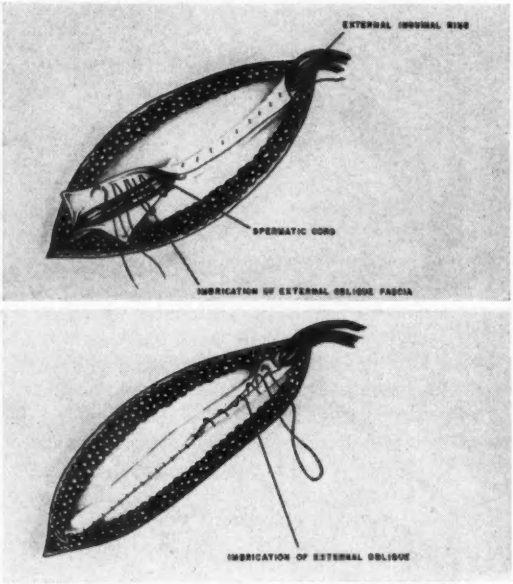

Figure 7.—Two stages of imbrication, showing use of medial leaf of external oblique fascia.

carried out as shown in Figure 7 in two layers of wire. A continuous layer of 3-0 plain catgut is used to approximate Scarpa's fascia, incorporating external oblique fascia to obliterate all dead space; and the skin then is closed in the usual manner with silk or wire.

COMMENT

Since small vessels do not retract to permit formation of clot when infiltration local anesthesia is used, careful hemostasis is necessary. However, the advantages of local anesthesia far outweigh this small burden. Another point to be emphasized is that dissection must be exceedingly clean and that all tissues not contributing to the final repair must be excised. This is particularly true in cases of recurrent hernias where much weak scarring and attenuated muscle is found around the cord. If sharp dissection is carried down to the vas and the vessels that serve it, the scar will be found to fall away and be more readily excisable. This not only thins out the cord but permits good visualization of important tissue planes. Care must be taken not to sacrifice too many spermatic vessels, for, as Halsted[2] pointed out, this leads to edema and atrophy of the testicle.

The major difference in the dissection part of this technique, as compared with most other methods, is the complete transection of transversalis fascia from the internal ring to the pubic spine. Its advantages are that it brings into view a fascial layer which has never been described as being deliberately used in hernia repair. This layer is the under surface of the rectus sheath and/or transversalis fascia and conjoined tendon. There is usually a firm fascial border which can be used nicely in forming the first and second layers of the repair. In contradistinction to this good layer, the lateral leaf of transversalis fascia in the more extensive hernias is often frayed and almost nonexistent. In such cases this leaf only serves to assist in taking up the slack in the floor, with Poupart's ligament being engaged to support it in the second layer. Another important advantage of opening the transversalis is the access that it gives to the femoral ring. A not inconsiderable proportion of so-called recurrent hernias are ascribable to overlooked femoral defects. As to the other direction, superior and lateral to the internal ring, Koontz[4] emphasized the importance of recurrence in that area. There, too, by use of the method here described, defects can be detected easily and repaired. One great advantage of wire for sutures in event of infection of the wound is that it does not have to be removed. It does not seem to hinder or prolong drainage; indeed it gives support until granulation and fibrosis fills in after the infection. A disadvantage is that wire is much more awkward to handle until one becomes experienced in its use, and care must be taken that it does not kink, for it may break at the site. Also, it can cut through tissue if drawn too tight. But these are difficulties, not contraindications.

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Community Mental Health Services

Operation in San Jose

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• **Recent attempts to cope with the growing and costly problem of mental illness are progressively emphasizing prophylaxis and early detection and treatment. California has joined this trend forcefully since the passage of the Short-Doyle Act in 1957.**

San Jose is one of the communities with a Community Mental Health program, financed 50 per cent by the local government and 50 per cent by the State of California. It implements its program by offering consultative services to the city's public health nurses, police officers, teachers, social workers, ministers, sanitarians and members of staffs of a number of public and private agencies.

Results of the program have been: (1) Increased demand for education in mental health; (2) growing number of requests for case consultation in lieu of patient-referral to already overburdened psychiatric facilities, and (3) growing recognition by consultees of the importance of their own self-awareness.

A SURVEY OF CARE in the field of mental illness showed a progressively stronger emphasis on mental health and mental hygiene.[8] Psychiatry has its roots in the physician's attempts to grapple with mental illness on a scientific basis. But he did so, at first, only within the confines of the institutional setting. Now it is no longer possible to segregate out of the community all persons whose mental and emotional health are less than optimum. There are not enough hospitals, hospital beds or psychiatrists to do so. Perhaps it has been this very practical consideration as much as our new clinical insights that has altered the course of mental hygiene. Thousands are now treated in out-patient clinics and private offices. The "day hospital" and the "night hospital" have been born. Where formerly the doors were locked, now the hinges on state hospital doors have been oiled and patients move out as well as in. But unless we can prevent mental and emotional illness, our treatment programs still are just stopgaps.[3,10]

A beginning has been made in the prevention of mental illness where cause and effect are known. Thus, for example, cases of general paresis have become historically interesting rather than clinically problematic. It has been said that a meaningful preventive program cannot be built without knowing what causes the illness that is to be prevented. This is, of course, logical, but in an emergency—and looking upon mental illness as Public Health Problem Number One, perhaps we can refer to an emergency without stretching the facts too far—one uses many techniques, not only the tried and true.

In recognition of the need for a change of approach, agencies are working toward emphasis on programs concerned with the prevention of mental illness and the maintenance of good mental and emotional health. On July 10, 1957, a law was enacted in the State of California (Subchapter 3, Register 57, No. 19 of the California Administrative Code), known as the Short-Doyle Act, which facilitates optional action on the part of local governments wishing to establish mental health services.[1] In nonlegal language what this means is that if a local community wishes to establish community mental health services, the money it sets aside for this purpose will be "matched" by the State of California, provided the stated prerequisites are met. There are 11 states with similar legislation. In the State of California there are now 11 counties and one city with community mental health programs operating under this law. The purpose of this paper is to describe some of the services being rendered under this program in the City of San Jose.

San Jose is 50 miles south of San Francisco. In 1955 its population was 125,000. Today it has 160,000 residents. A projection made by the city predicts a population in 1970 of 800,000. Once largely agricultural, the economy is rapidly becoming industrial. The population is varied socio-economically and culturally. Twenty per cent of San Jose's public school children come from families in which Spanish is the predominant language. For this varied and growing population, the "Community Mental Health Service," now in its second year, is staffed by two psychiatrists, two clinical psychologists and one psychiatric social worker. The service is in the purview of the city's department of health.

San Jose's program is unique in that it provides no direct service such as is ordinarily provided in a

This article was read in manuscript and approved by Stanley Milstone, M.D., director of the Short-Doyle program in San Jose and by Dwight Bissell, M.D., health officer of the San Jose Health Department.

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mental hygiene clinic. There are other facilities for direct service, although woefully inadequate as is true in so many communities today. In addition to 18 psychiatrists in private practice, there are three Community Chest supported agencies and three public agencies, all of which provide treatment and/or counseling services, and all of which are unable to provide enough services to meet the community's demand. (One of these agencies has a "waiting list" of one year's duration.)

The Community Mental Health Service attempts to promote mental health by increasing skills in interpersonal relationships and by effecting attitudinal changes in public health nurses,[4,9] teachers and school administrators,[6] social workers, ministers, sanitarians, police officers, and members of staffs of several other community agencies,[7] so that these "caretakers" will be more effective with their patients, students, clients and charges. The underlying rationale includes doing what New York City's health commissioner, Dr. Leona Baumgartner, called, "building up the capacities of those less well-trained to take over part of the work." This is not to be confused with making the "caretaker" into a pseudo-psychiatrist. Techniques for achieving the above-mentioned goal range from talks to large groups of professional workers or laymen, to small discussion groups and individual consultations.

Perhaps some illustrations from current projects will bring the program into clearer focus:

1. About a dozen clergymen formed a group in order to discuss some of the problems common in all pastoral counseling and asked the San Jose Community Mental Health Service to supply a discussion leader. One of the psychiatrists has been serving in this capacity for more than a year. He meets with the clergymen, all of whom are ministers in local Protestant churches of different denominations. The discussions began on a fairly objective level, but soon, according to the consultant, group members began to interact on the basis of feelings and subjective reactions to the church situations under discussion. Expression of affect and interaction can then be interpreted by the psychiatrist.

2. A relatively small industrial concern, whose staff does include a physician, nurse, psychologist and social worker, asked the Community Mental Health Service to supply a consultant with whom it might explore the relations of the staff with the board of directors and also intrastaff relationships. One of the Community Mental Health Service psychologists has been offering consultation in this setting for a year, exploring with the staff, both individually and in groups, some of the feelings evoked by previous and present experiences with authority figures; reasons sometimes underlying breakdown in communication; the effects of punitive attitudes; and the evolution of certain biases which impede optimum functioning.

3. Some of the school districts in San Jose have asked that the Community Mental Health Service social worker meet with their teachers and principals for (a) case consultation and (b) the purpose of eliciting general attitudes evoked in the teaching profession which affect—either in a salutary or deleterious manner—the behavior and development of students. Such requests are welcome since, to quote Dr. Frank Hladky, Jr., of the Rip Van Winkle Clinic's Guidance Service, ". . . the schools are one place where we can pick up situations early and try to do something about them. If teachers gain understanding and knowledge of emotional problems in children, it may help them to help children without their needing actual psychiatric help later on."

4. At the time the San Jose Community Mental Health Service came into being, the San Jose Police Department was showing an interest in the possibility of in-service training courses covering subjects such as commitment laws, the etiology of mental and emotional illness, techniques in dealing with mentally ill persons and the like. One of the psychologists, together with representatives of the local chapter of the National Association for Mental Health, organized a series of discussions around these subjects for the police officers.

5. A final project chosen for mention is one of several currently being carried on with the public health nurses of the City Health Department. This particular project is under the direction of one of the Health Department's physicians with psychiatric orientation. It involved the organization of a special Child Health Conference, patterned in part after the work of Levy,[5] with the following objectives:

- To help make staff personnel more observant of parent-child, parent-parent and intrastaff relationships and behavior.
- To study attitudes of Child Health Conference personnel and parents.
- To learn how to recognize and assess more quickly emotional problems in children, parents and families.
- To explore methods of giving help adequately and quickly in the face of emotional problems or potential problems.
- To explore what can be done to promote good mental health attitudes in child health conferences and other public health situations.
- To improve interview techniques.
- To learn methods used by parents in child management.

The Community Mental Health Service social worker and one of the psychologists are an integral part of this Child Health Conference. They are involved as participant-observers during the conference itself, and active in the pre-conference and post-conference discussions.

The program director, as dictated by law, is a board-certified psychiatrist. Assignment of psychiatrists, social workers and psychologists to individual projects has been made on the basis of interest and experience rather than on the basis of academic degree.

One of the interesting questions raised by the San Jose Community Mental Health Service staff is whether services rendered should be self-perpetuating, and thus limit the scope of activity in accordance with the size of the staff, or whether some of the projects might be considered in the nature of demonstrations. The staff tends to lean in the latter direction, feeling that an agency which benefits from services rendered may want, in time, to employ its own mental health consultants, thus freeing Short-Doyle personnel to take on new tasks. In one school district this has happened already in the guise of the district's employment of a clinical psychologist as mental health consultant.

Another question has to do possibly with semantics. According to the Short-Doyle Act, in addition to those clinical facilities directly serving patients, two kinds of services "promoting the mental health of the community" are recognized. One is called, "informational and educational service" and the other, "mental health consultation." When necessity demands categorizing a particular project as one or the other, the staff often asks itself how one draws a line between the two, whether a line can be drawn, and what the significance of such a division might be.

It is too early to make a valid assessment or evaluation of the total program but, looking back over the past year, it becomes obvious that whether or not a specific program came into being depended as much on the groundwork which had previously been prepared for consultation as any other single factor.[2]

A potential danger in this service should be pointed out. Since consultation is offered not to psychiatric patients, but to professional workers, the mental health consultant must remind himself that he is not an expert in education, nursing, pediatrics, rehabilitation, police administration and the like. The program would be doomed to failure if the consultees felt their professional worth were being scrutinized by individuals untrained in their respective fields of competence. A psychiatrist, psychologist, or social worker cannot guide a teacher in methods of teaching, a minister in theological precepts or a police officer in law enforcement techniques. What he can do is to help the consultee understand some of the dynamics underlying human behavior and relationships in such a way as to make his skills and training more effective. And, further, he can broaden his own horizons by learning more about educational philosophy from his school-consultees, about law enforcement problems and techniques from police officers, about public health nursing and its aims from the public health nurse-consultee.

Results of the program's impact on the professional workers to whom service is given are evident in:

- Increased demand for didactic presentation of mental health information and concepts;
- More requests for case consultation in lieu of immediate referral to other agencies for psychiatric diagnosis and treatment, and
- Growing recognition by consultees that self-awareness is basic to improvements of interpersonal relationships.

In contrast to situations in which emotional disease may be the main concern of psychiatrist, clinical psychologist and psychiatric social worker, here the focus is on the professional worker who can learn to recognize personality dynamics and thus (a) encourage assets; (b) be forewarned in the presence of potential maladjustment, and (c) play a role in the reduction of exogenous and endogenous tensions.

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Corneal Contact Lenses

Special Value in Severe Anisometropia in Children

ALBERT A. STEINER, *M.D.*, San Francisco

• **Careful selection of patients and skillful fitting result in a high rate of success with corneal contact lenses—over 96 per cent in 339 patients treated in the present series. The lenses were especially valuable in anisometropia in children (11 cases). Children can be taught to care for contact lenses and insert and remove them for themselves.**

SEVERAL ARTICLES on corneal contact lenses have appeared in the medical literature in recent years. There is no intention here to add another series of statistics, but rather to emphasize the value of careful selection of patients and proper fitting, especially in the case of children with severe anisometropia.

Westsmith[5] recently summarized a questionnaire survey of patients who had been fitted with corneal contact lenses; fewer than 50 per cent responded, and among these the rejection rate (those dissatisfied with the lenses) was 9.7 per cent. Among 339 patients at Greens' Eye Hospital, all of them completely followed (which is in itself evidence of general satisfaction) the proportion who rejected the corneal lenses was 3.2 per cent or, if the admittedly experimental cases are eliminated, 2.3 per cent.

Most of the patients are young adults; 33 are over 61 years of age, 21 are under 15, the youngest 5½ years old. Rejections were twice as frequent among the 146 males as among the 193 females. Nearly as many patients use corneal lenses for medical reasons (45 per cent) as for cosmetic reasons (48.5 per cent); a few (6.5 per cent) wanted them primarily for participation in sports. The great majority wear the lenses 13 to 16 hours a day; only 5 wear them less than eight hours.

Nine patients have rejected the lenses, four of them after less than two months' trial. Two objected to "stinging"; 2 had diplopia; 2 found allergic reactions aggravated; 1 was senile, and 1 found them "too much trouble." In the other three cases the use of corneal lenses had been considered experimental. In one case for optic atrophy, in another for a telescopic lens arrangement, and in the third for healed corneal ulcer, which interfered with the fitting.

The eye defects in these cases are best considered by the number of eyes affected, as summarized in Table 1. A special note should be made with regard to monocular aphakia. Spaeth[3] and others have stated their preference for the corneal contact lens in this condition, though Ogle, Burian and Bannon[2] insist that it is rarely possible to reduce aniseikonia (difference in the size and shape of the images of each eye) to less than 9 per cent; patients who are comfortable in spite of the aniseikonia, these investigators believe, have some degree of suppression or are satisfied with confused peripheral vision. Be that as it may, most patients feel comfortable and have better vision with a corneal lens. None of the monocular aphakic patients showed any suppression as tested on the major amblyoscope.

This presentation is intended to emphasize especially the value of corneal lenses for children. Eleven cases of severe anisometropia (difference in refractive power of the eyes) in children are summarized in Table 2. This defect is sometimes discovered because of a deviating eye, in other cases through acuity tests at school. These children were remarkably cooperative, as were their parents, who were greatly encouraged by demonstrable improvement and assisted willingly in maintaining patching of the good eye to improve the amblyopic one. The improvement is maintained if the eyes are straight or can be surgically straightened, though repeated patching may be necessary in some cases. The visual acuity in the anisometropic eye is much better with a corneal contact lens than with a spectacle lens.

Corneal contact lenses may be useful, too, in severe myopia of both eyes. Some children in schools

Submitted November 9, 1959.

TABLE 1.—*Rejection of Corneal Contact Lenses in 339 Cases*

Condition	No. of Eyes	Rejections	
		No.	Per Cent
Myopia (more than half over 5 diopters)	320	4	1.25
Hyperopia (majority over 3 diopters)	43	3	7
Astigmatism, myopic or hyperopic (all over 1.5 diopters)	58	1	1.7
Aphakia, monocular or binocular	83	3	2.8
Keratoconus	25	0	0
Anisometropia	23	0	0
Corneal scarring	6	1	16.6

TABLE 2.—*Anisometropia in Children Treated with Corneal Contact Lenses*

Age	Sex	Eye Defects	Treatment	Corrected Vision
5½	M	Right: Divergent strabismus 40△ due to right severe myopia.	Contact lens, now worn all day. Normal left eye patched. Strabismus to be surgically corrected.	Right, 20/400. Exotropia 25△ and varying.
6	F	Right: Vision 20/350, divergent strabismus 6△, hypertropia 4△.	Contact lens worn all day. Left eye patched. Treatment being continued.	Right, 20/120.
7	M	Right: Vision 20/1000, severe myopia, divergent strabismus 12△, hypotropia 10△.	Contact lens worn all day, left eye patched daily after school. Strabismus surgically corrected.	Eyes straight. Right, 20/120.
7	M	Right: Vision 20/1000, severe myopia, convergent strabismus 15△.	Contact lens worn all day, patching for long periods refused. Strabismus to be surgically corrected.	Right, 20/40.
7	F	Right: Vision 20/350, severe myopia, convergent strabismus 30△.	Contact lens worn all day, left eye patched after school. Right strabismus surgically corrected.	Right, 20/120, eyes straight.
8	F	Left: Vision 20/1000, severe myopia, eyes straight.	Contact lens worn all day, no patching.	Left, 20/60.
7	M	Left: Vision 20/200, severe mixed astigmatism, eyes straight.	Contact lens worn all day, patch right eye.	Left, 20/25.
8	M	Left: Traumatic cataract.	Cataract removed, contact lens worn all day.	Left, 20/20.
9	M	Left: Vision 20/1000, severe myopia, eyes straight.	Contact lens worn all day, right eye patched.	Left, 20/60.
10	F	Left: Vision 20/200, severe myopia, eyes straight.	Contact lens worn all day.	Left, 20/25.
12	M	Right: Traumatic cataract.	Cataract removed. Contact lens worn all day.	Right, 20/20.

△ = prism diopters.

for the partially sighted have been sufficiently improved through these lenses to transfer to public schools.

The most dramatic improvement in visual acuity is obtained in keratoconus (conical protrusion of the cornea), although fitting is the most difficult in this condition. Patients who formerly tolerated a scleral lens for no more than six hours at a time were able to wear a corneal contact lens for 16 hours a day with minimal corneal irritation.

During the fitting period, children tend to lose lenses frequently, but as they begin wearing them for longer periods they also learn to care for them and they lose them less often. Insertion and removal of the lenses by the parents is another fitting problem. If parents are willing, children over 10 years of age are trained to handle the lenses for themselves.

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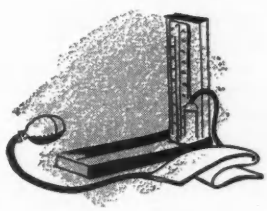

CASE REPORTS

Recovery from Heat Prostration and Body Temperature of 109° F.

M. P. AJALAT, M.D., Calexico

SO FAR AS COULD be determined by inquiry and review of the literature, there is no previous record of a patient's recovering from heat prostration in which the temperature reached (and may have exceeded) 109° F., as occurred in the present case.

REPORT OF A CASE

The patient, a 56-year-old Mexican crop worker, apparently previously in good health, collapsed while at work in the field and was immediately put into hospital. Atmospheric temperature at the time of this occurrence was 114° F. in the shade.

On admittance to hospital the patient was unconscious and had fecal incontinence. The blood pressure was 100/50 mm. of mercury, respirations were 18 a minute and the pulse was weak and thready at a rate of 120. Rectal temperature was at least 109° F., the highest point that could be registered on any of the clinical thermometers available. (Three thermometers were used to make sure, and the column of mercury reached that limit on all of them.) The patient was immediately put into a bathtub, where ice packed about his body melted quickly.

Infusion of 1,000 cc. of 5 per cent glucose in saline solution was begun at 3 p.m. while the patient was still in the tub. At 3:45 the temperature was 106° F. and at 4 p.m. was 103°. Taken out of the tub then and put to bed, the patient became conscious but, as he was irrational and hard to manage, he was strapped down and 100 mg. of promazine hydrochloride (Sparine®) was given intramuscularly. Still intractable an hour later, he was given 100 mg. of meperidine (Demerol®). At 6 p.m. the temperature was 97° and the patient was quieter, and 9 o'clock that night the temperature was 99°. The following morning he was cooperative but confused and irrational, not remembering what had happened the day before. By evening he was less irrational and the temperature was normal. He became normal in every respect in the next few days and he was discharged from the hospital six days after entering, without either physical or mental residual effect and with all reflexes normal.

Submitted July 2, 1959.

SUMMARY

A patient with heat prostration, the body temperature reaching at least 109° F., recovered in a few days and had no residual abnormality.

319 Third Street, Calexico.

Congenital Varicella with Primary Varicella Pneumonia

TIMOTHY F. BREWER, M.D., Los Angeles

A RECENT REPORT[2] of primary varicella pneumonia mentioned that only five cases have been reported in persons under the age of 19. The case here reported is perhaps the first case in the literature of primary varicella pneumonia complicating congenital chickenpox, with the patient recovering.

REPORT OF A CASE

A 14-day-old white baby was admitted to the Communicable Disease Unit of the Los Angeles County General Hospital on August 24, 1959, with chickenpox. Chickenpox developed in his mother five days before delivery. At birth the baby was isolated from her, was observed in the hospital for two days, then discharged to the care of his grandmother. When he was ten days old, vesicular exanthem developed on the chest and abdomen, and his grandmother said he had fever. Three days later the body temperature rose to 102° F., two convulsions occurred and the patient was returned to the hospital.

The only abnormality noted on physical examination at that time was a papulovesicular rash, in all stages of development, over the entire body.

The rectal temperature was 102.2° F., the pulse rate 140 and respirations 60 per minute. The body weight was 6 pounds and 14 ounces (weight at birth was 8 pounds, 2 ounces).

Leukocytes numbered 10,600 per cu. mm.—52 per cent polymorphonuclear cells and 48 per cent lymphocytes. Hemoglobin content was 16 gm. per 100

From the Communicable Disease Service of Albert G. Bower, M.D., Chief Physician, Los Angeles County General Hospital, Los Angeles 33.

Submitted December 21, 1959.

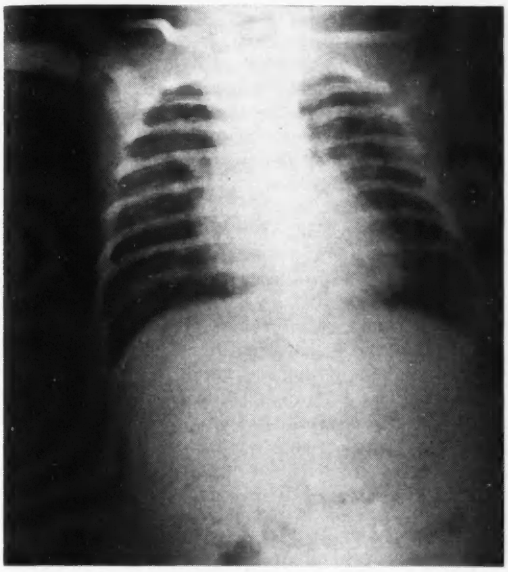

Figure 1. — Multiple patchy densities are evident throughout both lung fields.

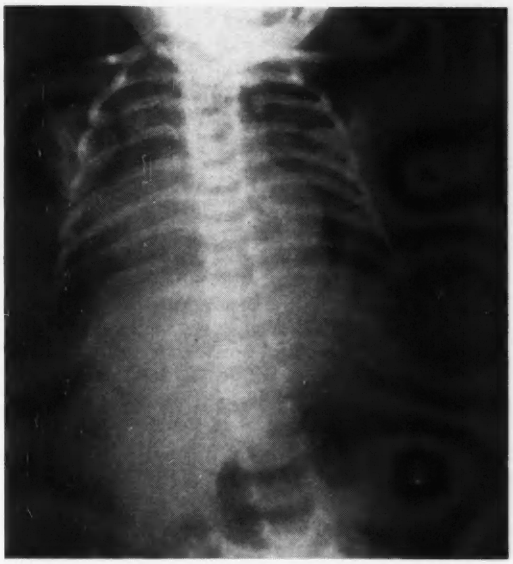

Figure 2.—The densities in the right lung field are now confluent, the left is unchanged.

cc. of blood. The urine gave a one plus reaction for albumin but was otherwise normal. Upon lumbar puncture, the opening pressure was 225 mm. (water) with the baby quiet. The puncture was traumatic and slightly cloudy fluid was obtained, containing approximately 1,300 erythrocytes and 27 leukocytes —all lymphocytes—per cu. mm. Sugar content was reduced by 4 drops of solution, and there was a faint reaction to a Pandy test.

The initial impression was varicella with encephalitis.

The patient was admitted to the ward and, except for the administration of 11 cc. of gamma globulin, was given only symptomatic treatment. Shortly after admission, harsh breath sounds without rales were noted in both lungs. An x-ray film of the chest taken at this time showed widespread patchy densities throughout both lung fields, which were believed to be due to primary varicella pneumonia (Figure 1). The baby was then given procaine penicillin, 600,000 units intramuscularly every twelve hours, chloramphenicol, 50 mg. intramuscularly every eight hours, and prednisone according to the following schedule: 10 mg. every six hours for four doses, then 10 mg. every eight hours for three doses, then 5 mg. every six hours for four doses. He was also placed in a croupette with oxygen flowing at six liters per minute.

The following morning the body temperature was 99.4° F. rectally and he was much improved. On the fourth day in the hospital, with the antibiotic dosage unchanged but the steroid dose reduced to 5 mg. twice daily, rib retraction upon respiration developed and the patient became restless and anorexic. Therefore, the dosage of prednisone was increased to 5 mg. four times daily. The rectal temperature was

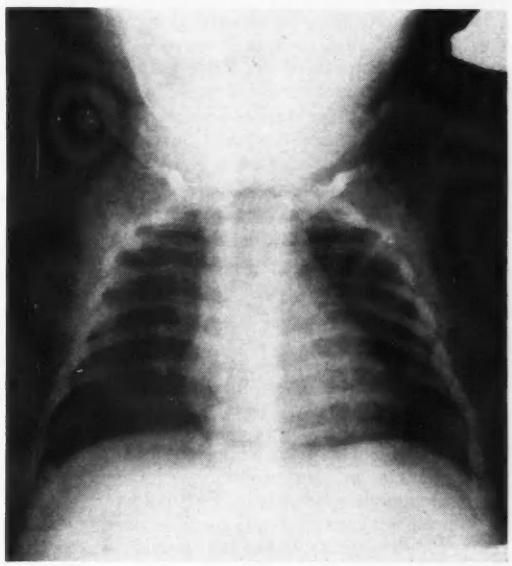

Figure 3.—Complete resolution of previous infiltrates is seen.

100.0° F. and it increased further to 100.8° F. for one day, then declined to 98.6° F., and the patient then remained afebrile. An x-ray film of the chest at the time of relapse showed that the infiltrate in the mid-lung and lower lung fields on the right had become confluent (Figure 2). The left lung was unchanged. Use of the croupette was discontinued on the fifth hospital day. On the eighth day the lungs became clear to auscultation.

After four days at 5 mg. four times a day, the

steroid dose was reduced to 5 mg. three times a day for four days, to 5 mg. twice a day for four days, to 2.5 mg. every eight hours for three days, to 2.5 mg. every twelve hours for two days and finally to 2.5 mg. daily for two days. Each day for the last four days of steroid treatment, 20 units of corticotropin (ACTH) gel was given intramuscularly. The total amount of prednisone given was 290 mg.

Antibiotics were discontinued at the same time as the steroids, on the twenty-first hospital day.

An x-ray film of the chest at the time of discharge showed considerable improvement, only patchy areas of consolidation remaining. Because of the known lag[13] between clinical condition and the roentgenographic appearance of the lungs, this was not considered a deterrent to discharge. The total stay in hospital was 30 days.

When examined again two weeks after leaving the hospital, the child was doing well. The lung sounds were normal and an x-ray film showed no lesions (Figure 3).

DISCUSSION

In this case, many of the previously tried agents for treatment were used—antibiotics, croupette, gamma globulin and steroids. Antibiotics have been tried numerous times before and it seems to be generally agreed that they may serve as prophylaxis against secondary invaders but do not influence the course of primary varicella pneumonia.[3,5] In this case, the patient's condition became worse while he was receiving antibiotics, and improved with no change in either dosage or type of antibiotic. The same is true of the croupette.

Gamma globulin has been advocated as a treatment for varicella[12] and has been used in primary varicella pneumonia[5]; but in the present case it appeared to have little if any effect, the condition of the patient having become worse after it was given and then improving without further use of gamma globulin.

That leaves the steroids, which, it is believed, were life-saving in this patient. The patient's condition fluctuated in a direct relationship to the daily dose of prednisone. The mode of action of steroids is not definitely known, but probably is related to their anti-inflammatory properties. Corticotropin may not have been necessary; it was used because of the relapse which occurred when the steroid dosage was first reduced.

The use of steroids in virus diseases is a problem which is far from settled. It has been assumed that virus diseases in general, and chickenpox in particular, are aggravated by the use of steroids.[9,10] Recently, however, this attitude has changed and steroids have been used in such virus diseases as herpes zoster, mumps orchitis and infectious hepatitis.[9] In the case of varicella pneumonia at least, it would appear that the question is not whether, but when. Primary varicella pneumonia occurs from the second to the fifth day after onset of exanthem—in the present case, on the fourth day. By then the rash is disseminated. The use of steroids at this stage would seem unlikely to cause further exacerbation but, as in the case here reported, may be life-saving.

Cases of primary varicella pneumonia are not numerous so that large series cannot be gathered to assess therapy. Bower[1] has reported fifteen cases from this hospital treated with steroids. His mortality was zero. Hunnicutt and Berlin[5] reported one case of a 26-year-old white female treated with 25 mg. prednisone daily. Her condition deteriorated before it improved. She also received antibiotics and gamma globulin in addition to supportive measures. Her dose of prednisone may have been harmful, it may have been insufficient, and it may have been ill-timed as she was still erupting when it was given. She recovered. Thompson and Cantrell[11] report the case of a 31-year-old white female successfully treated with prednisolone, 40 mg. daily at the beginning and then tapered over a two-week period. Other measures included tetracycline, oxygen, Alevaire,® and mild sedation. For the same reasons as in our patient it is doubted these other measures were more than supportive. Fitz and Meiklejohn[3] present the case of a 25-year-old white female treated with antibiotics and supportive measures without success, but responding rather rapidly when hydrocortisone was added to her regimen. Rosecan, Baumgarten and Charles[8] published the case of a 36-year-old white male treated with intravenous aqueous adrenal cortical extract and intramuscular cortisone. This case was complicated by shock both preceding and coincident with the use of steroids, and congestive heart failure following the use of steroids. As the electrolytes remained normal during treatment, the question of whether the steroids contributed to the failure is not documented. That should not be much of a problem today, however. Their patient recovered.

The mortality rate of primary varicella pneumonia has been reported as 16 per cent.[11] In this report, we have followed the courses of twenty patients treated with steroids, all of whom recovered.

Including our case, four cases of congenital chickenpox with primary varicella pneumonia have been reported.[6,7] We believe this is the first to have survived.

SUMMARY

In a case of congenital chickenpox with primary varicella pneumonia, steroids were used in the treatment. The patient recovered. This is believed to be the first successfully treated case. This therapy is considered to be worthy of further study.

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Skin Cancer in Smallpox Vaccination Scars

A Report of Five Cases

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NORMAN LEVAN, *M.D.*, Bakersfield

THE PURPOSE OF THIS ARTICLE is to report five cases of an interesting phenomenon—the formation of basal cell skin cancers within smallpox vaccination scars. This occurrence was observed independently by all of the authors, all of whom practice in Southern California.

CASE 1. A 54-year-old man was observed because of herpes zoster involving the left shoulder. It was noted that half the vaccination scar in the left deltoid area had been replaced by a typical basal cell carcinoma. The outer edge of the tumor had taken the exact shape of the scar. It was removed and microscopically identified as a basal cell epithelioma. The man had a densely freckled skin from the waist up, evidence that he had spent a great deal of time in the sun at some time in his life.

CASE 2. A 48-year-old man, seen because of a recent change in a smallpox vaccination scar in the right deltoid area, had a spongy, granulomatous mass about 1 cm. in diameter replacing the scar and sharply limited to the boundaries of the scar. The tumor was removed and proved to be a basal cell epithelioma. The vaccination scar which had become carcinomatous had been present since early childhood. Another vaccination mark was present about two inches lower on the right arm. This one was only seven years old and showed no signs of malignant degeneration. The patient had a densely freckled skin from the waist up.

Submitted October 1, 1959.

CASE 3. A 48-year-old Caucasian woman with a swarthy complexion was seen for the treatment of infected sebaceous cysts involving both earlobes. Upon examination, a dark, brownish-black tumor was noted in the right deltoid area. It measured 2 by 1.5 cm. and completely filled the site of a smallpox vaccination scar which dated back to early childhood. Removed, the tumor was identified as a pigmented basal cell epithelioma. Several years later a second basal cell carcinoma developed within a small, depigmented scar on the right forehead.

CASE 4. A 44-year-old white man was observed because of a lesion located within a smallpox vaccination scar in the left deltoid area. The lesion was removed and histologically identified as a basal cell carcinoma. Two years previously the patient had had a small basal cell carcinoma removed from the back of his neck and two years later another small one appeared on the left temple area.

CASE 5. A 53-year-old woman of Mexican ancestry was seen because of ulceration within the center of a tumor 6 mm. in diameter which developed within a smallpox vaccination scar which dated back to childhood. The lesion was removed. The pathologist reported it "basal cell carcinoma."

COMMENT

It is interesting to speculate on why the vaccination scars in these patients became carcinomatous. There is extensive literature dealing with the problem of skin cancer in scars. So far as could be determined, there was no suggestion that some scars, particularly those on exposed areas of the body, become malignant because of carcinogenic rays of the sun. We would like to suggest that the carcinomas in the present cases may have been so caused. Two of the patients had a swarthy complexion—the kind ordinarily resistant to sunlight. The skin at the site of vaccination scars, however, was thinner and paler than the skin elsewhere on their bodies, which perhaps reduced whatever protection swarthiness offers. In the mild climate of Southern California there is much more likelihood that the deltoid region would receive a toxic amount of sunlight than would be the case almost anywhere else in the world. We believe that this is one reason why five cases of this type would be seen within a relatively short time by physicians practicing in this area whereas there has been only one other similar case report in the world literature.[1]

On the basis of the five cases reported here (and two others observed by one of the authors, one of the patients dying) we believe that any change within a vaccination scar should be thoroughly investigated. Whenever the diagnosis is not immediately apparent, biopsy is advisable.

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California MEDICINE

For information on preparation of manuscript, see advertising page 2

EDITORIAL

The Governor's Committee

IN THE PAST FEW YEARS medical care has come to be ranked almost even with food, clothing and shelter among the essentials of humans. Whether owing to spontaneously occurring public demand for more and better care or to political hay-making, the fact is that the trend is clearly in the direction of classifying medical care almost as a basic human right.

Nowhere has this attitude been more apparent than in the efforts of political figures to place medical care in the category of a publicly-controlled utility. While such efforts have thus far been defeated in great part, the motivation still persists and efforts in this direction are still being made.

What Stalin did in Russia, Bismarck in Germany and Lloyd George in Great Britain, some American politicians would seek to duplicate today. The fact that the nationalization of medicine in those countries was a forerunner to a complete socializing movement seems to bother some American public figures not at all; to them, political expediency indicates the desirability of absorbing into the public domain an entire profession of skilled practitioners for the sole end of making their services a largesse to be distributed by those in power in our national or state capitals.

Thus, while the medical profession in California certainly can welcome and abet the stated aims of the Governor's Committee on Study of Medical Aid and Health, surely physicians can be forgiven some cautiousness of attitude, in light of the purposes to which many another political "study" has been put in the past two decades, until it becomes quite certain that the inquiry is not somehow deviously to be made a bureaucratic vehicle to deliver the practice of medicine into the control of a state agency.

Acting on whatever motive, Governor Brown early last year created a group of six people, one drawn from the public and the other five from career people in departments of the State of California. This group was instructed to review the health needs and health care of the people and to recommend proposals for making improvements.

The report of this group, strictly an inside affair in the government of the state, was completed last October. The group found, in a brief report (which offered no documentation) that the people of California needed more in the way of health care, that facilities in this field needed an overhauling, that the costs of health care were beyond the means of the people and that something ought to be done about the whole thing.

The "something" was a proposal for appointment of a representative committee of citizens, charged with surveying the whole field of health care and advising the Governor as to areas where legislative action would be needed to assure more, better, more available and less costly medical services for the population.

The Governor acted promptly and named a committee of 17 citizens to make this survey. The members were drawn from the fields of education, labor, law, medicine, hospitals and consumers. Later on, representatives of dentistry and nursing were added, to make a 19-member group. Fortunately, in the medical profession and others, his appointments were of outstanding men. The physicians on the committee are Paul D. Foster, president of the California Medical Association, T. Eric Reynolds, the immediate past president, and Roger O. Egeberg, medical director of the Los Angeles County Department of Charities.

For the past three months this committee has met and met again, always under the urgency of a November 1, 1960, deadline for its final report.

During these same three months it became obvious that research into the field of health care is just like research into anything else—every time you put down a point to be explored, a dozen more spring up as corollaries. The job keeps growing.

In these circumstances the committee members—all but a few of them people who have regular vocations and serve as volunteers—cannot possibly encompass the field of inquiry which has been opened up. Consequently, they must leave the performance of the research to the professional staff people who have been assigned from various departments of the state government. The committee members have been presented with a list of research proposals which even the professional staff cannot study with justice and objectivity in the short time available.

The picture thus resolves itself into a group of citizens, each with his own private or personal interests, serving as listening posts to a group of state employees who, serving under state agency conditions as they do, hardly can be expected to make recommendations to decrease the position of the state government in providing services by the government for the voters.

Physicians have a vital interest in this whole procedure, since they represent the keystone in the structure of medical care. As matters now stand, it might happen that next November when the report of the committee is made, a Citizens' Committee will somehow seem to be involved in a recommendation that physicians become virtually state employees and that medical services shall become a property of the state, to be dispensed under such conditions as state officials dictate.

Many physicians have been only vaguely aware of the existence of this committee and very few of them have had any information on the lines of study being followed by the committee. Where these facts are known, it becomes obvious that a serious threat to the private practice of medicine may emerge from this particular operation.

It is vital to the welfare of the profession that the studies and procedures of this committee and of its "task forces" that have been named to review various facets of the overall inquiry must be carefully followed, studied and analyzed. Should the final report of this group include recommendations for the taking over of medical practice as a state prerogative, to be dispensed under the direction of an agency of the state, the profession will find itself again in the unenviable position of defense.

The events of 1945 in California, and national events of 1948 under the Wagner-Murray-Dingell proposal, are still fresh in many minds. Let us hope that the Governor's Committee on Study of Medical Aid and Health will not stir up another battle comparable to these two. The medical needs of the people are too demanding to afford such a diversion of medical resources and medical thinking.

Positive Public Relations

THE PROFESSION of medicine has suffered in recent years by the outspoken and reiterated accusation by social or political adversaries that medical organizations are always against something and are in reality an economic combination of physicians interested only in advancing their own welfare. Such epithets as "the medical trust" are typical of this sort of abusive attack.

The many and constant activities of organized medicine that are entirely in the interest of better medical care and better health for all people are rarely celebrated, perhaps because they are, in a word—a word that here can be used with pride—ordinary.

Several weeks back the then president of the California Medical Association, Doctor T. Eric Reynolds, gave the lie publicly to this sort of accusation. Interestingly, his calm and unemotional report, distributed to the press, drew a good response from editors who saw fit to run the story and quote liberally from it.

Doctor Reynolds concentrated his statement on two principal items. First, the matter of membership growth of the California Medical Association and, second, the contributions by California physicians to the American Medical Education Foundation for the training of future physicians.

The C.M.A. membership, he pointed out, has gone steadily upward for a number of years. This belies the charge that physicians seek to keep out newcomers as a means of retaining all the medical practice in the area. As to contributions to the A.M.E.F., he pointed to the unique position of a profession contributing money from its members' pockets to train new physicians who, from a strict economic point of view, are potential competitors.

It is easy to supplement Doctor Reynolds' statements to show how medical organizations work in the public interest. From either the state or the county society level, the list of accomplishments *pro bono publico* is not only long but the efforts that have been made have been remarkably efficient.

The California Medical Association and its component societies have set up services for the placement of physicians seeking to locate in the state. They have established blood banks in strategic locations and banded them together into a clearinghouse system which guarantees any patient any amount of any type blood he needs, when he needs it.

They provide the Cancer Commission which car-

ries on a continuing program of seeking out and disseminating what is new and good in the field of cancer research and treatment, and of exposing quackery.

They have set up emergency telephone systems to locate individual physicians or to secure the services of another physician in case of emergency. They have sponsored medical sections of disaster relief organizations which have reacted instantaneously and effectively in time of need. A fine example was seen in the recent railroad-truck crash in Kern County, where volunteer medical services were credited with saving many lives and alleviating or reducing the seriousness of a large number of injuries.

The county societies have also set up referral services which are open to new residents of an area who need help in selecting a family physician or a specialist. They have participated in a number of immunization programs in the public interest. They have established review committees where patients may appeal from controversies with physicians.

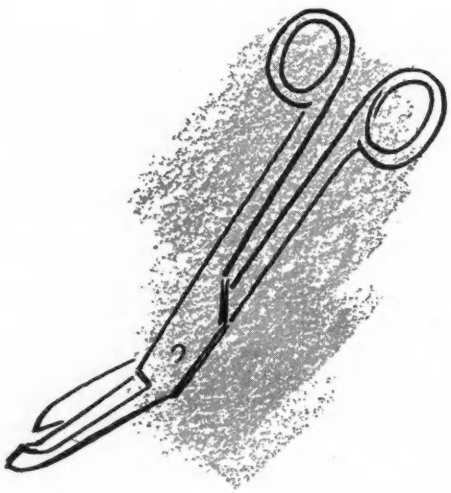
They cooperate with public and other officials in the interest of traffic safety. Peace officers, firemen and other officers work with them for the alleviation of suffering in accident and similar cases where only the professional skill of physicians can contribute so much good for people.

Often overlooked but certainly not forgotten are the services of medical societies in staffing county hospitals, where the indigent patients receive the finest in medical care at no cost to themselves or to their county governments and in the operation of clinics for indigent and low income groups.

These are a few of the services which medical organizations can and do perform. These are some of the things that physicians in organized groups can accomplish that individual physicians can not.

Many physicians are growing weary of the oft-repeated charge that the doctor as an individual is a fine person but that somehow the organization that he has created is an evil, self-seeking cartel. Critics who voice this sentiment are prone to forget that these organizations are made up of fine individual physicians and that through organization they enhance and extend the powers for good of the individual.

A simple analysis of some of the functions of medical organizations brings to light the many fine public services performed by these groups. Critics of medical associations, whatever their motives, are invited to name any other professional, business, labor or trade organization which can match the record of public service of medical associations. *Res ipsa loquitur.*



California MEDICAL ASSOCIATION

NOTICES & REPORTS

Transactions of the House of Delegates

Los Angeles, February 21-24, 1960

Note: The following report of the transactions of the House of Delegates of the California Medical Association is selected and abridged. A complete transcript of all proceedings is on file in the Association office in San Francisco and available for the inspection of all members.

REFERENCE COMMITTEES

COMMITTEES APPOINTED by Speaker James C. Doyle at the first meeting of the House of Delegates Saturday evening, February 20, were as follows:

Committee on Credentials: Wells C. Cook, Los Angeles, chairman. (To facilitate registration, the Speaker and Vice-Speaker last year inaugurated two Registration Boards, one to deal with the registration of the Los Angeles delegation, the other to handle the delegates from all the state except Los Angeles.)

Los Angeles Delegation: A. J. Murrieta, Jr., Los Angeles; Don J. Hunter, North Hollywood; Jay B. Cosgrove, Los Angeles, alternate.

All except Los Angeles: Melvin Hart, Oakland; Nathan Dubin, Lincoln; Robert B. Smalley, Willits; L. H. Fairchild, Carlsbad, alternate.

Reference Committee 1. (This committee reviews the reports of the officers, the Council, the commissions, and standing and special committees.) Fred E. Bradford, Los Angeles, chairman; Willard Newman, San Diego; James Yant, Sacramento; E. E. Wadsworth, San Gabriel, alternate.

Reference Committee 2. (This committee reviews the reports of the secretary and the executive secretary and studies and makes recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year.) Robert L. Dennis, San Jose, chairman; Lawrence F. Whittaker, Huntington Beach; James J. Benn, Jr., Ripon; William Kaiser, Berkeley, alternate.

HEARINGS ON C.M.A. CONTINUING EDUCATION AND SCIENTIFIC ACTIVITIES

The C.M.A. Committee on Continuing Education and Scientific Activities will hold two open hearings within the next two months. One is scheduled for 9:30 a.m., June 19, at the Hilton Inn, International Airport, San Francisco. The other will be held July 10 beginning at 9:30 a.m., at the Hyatt House, 5547 Century Boulevard, Los Angeles.

Any C.M.A. member wishing to appear at either meeting is invited to do so.

Reference Committee 3. (This committee considers new and miscellaneous business.) Joseph Telford, San Diego, chairman; Elmer Gooel, Beverly Hills; Don C. Musser, San Francisco; John F. Murray, Fresno, alternate.

Reference Committee 3A. (This committee will supplement the efforts of Reference Committee 3 which in the past has carried a far heavier burden than it should.) Robert C. Combs, San Francisco, chairman; William F. Quinn, Los Angeles; Frederick T. Hunt, Santa Ana; John D. Coughlin, San Bernardino, alternate.

Reference Committee 3B. (This committee also is a supplement to 3 and 3A.) Charles E. Grayson, Sacramento, chairman; Albert Miller, San Mateo; Harold B. Miles, Santa Barbara; Charles L. Dimmler, Jr., Piedmont was an alternate, but because of the illness of his wife, he is unable to be with us.

Reference Committee 4. (This committee considers amendments to the Constitution and By-Laws.) Roberta Fenlon, San Francisco, chairman; August J. Haschka, Pacific Palisades; Frank C. Melone, Ontario; Walter H. Brignoli, St. Helena, alternate.

Reference Committee on California Physicians' Service. Ben D. A. Miano, San Bernardino, chairman; Wilbur G. Rogers, Glendale; Edward Liston, Palo Alto; Seymour Strongin, Bakersfield, alternate.

The Constitution Study Committee. C. J. Attwood, Oakland, acting chairman; Sam J. McClendon, San Diego, chairman; Robb Smith, Orange Cove; Carl Hadley, San Bernardino; James Moore, Ventura; Fred Olson, Fortuna; James Yant, Sacramento; Jay J. Crane, Los Angeles; Leslie Magoon, San Jose; Edgar Wayburn, San Francisco; Edward Levy, San Diego.

* * *

PRESENTATION OF FIFTY-YEAR AWARDS

Pins commemorative of 50 years of membership in the California Medical Association have been presented to the following physicians:

Dr. Eugene V. Falk, Modesto.
Dr. Thomas L. Rogers, Long Beach.
Dr. Clayton G. Stadfield, Idylwild.
Dr. Robert T. Sutherland, Oakland.

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STUDENT A.M.A. REPRESENTATIVES

The representatives from California medical schools to the Student American Medical Association were introduced:

From Stanford University: Duane Gainsberg and Gordon Calloway.

From the University of California, San Francisco: Richard Mauer and Lester Ulein.

From the University of Southern California: Craig Johanson and Betty Bernard.

From the University of California at Los Angeles: Hal Allen and Dave Cryan. And there are two others from U.C.L.A.: Paul Holland and Duane Townsend.

From the College of Medical Evangelists: Edwin Urich and Eugene Shakespeare.

* * *

WOMAN'S AUXILIARY

Mrs. T. A. Poska, president of the Woman's Auxiliary to the California Medical Association, reported on the activities of that organization in her year of tenure. The report was published in the April, 1960, issue of CALIFORNIA MEDICINE, page 309.

C.P.S. BOARD OF TRUSTEES

The following is an abstract of a supplemental report of the C.P.S. Board of Trustees that was made by Dr. Arlo A. Morrison, president of the Board:

The number of beneficiary members as of December 31, 1959, was 781,281, a gain of 6 per cent in the calendar year.

Income from commercial programs rose to $39 million. After provision for reserves and administrative expense, approximately $32 million of this amount was disbursed in payments to providers of services under these programs. In addition about $18 million was received and disbursed under the Veterans, the Medicare and the Public Assistance government programs.

Administrative expense was reduced by $230,000 in 1959 as compared with the previous year, and further savings are in prospect as automation is extended and processes are speeded.

C.P.S.'s reserve account was well above $13 million as of December 31, 1959, a figure somewhat above the amount needed to meet the recommendation of the National Association of Insurance Commissioners with regard to Blue Shield plans.

Doctor Morrison reviewed the history of the adoption of legislation to provide health insurance benefits for federal employees and pointed out that the law had been passed with a suddenness which had not been anticipated. Since the federal law covered all federal employees and crossed state lines, he said, the Blue Shield Commission, which has been active since 1946, became the agency of the prepayment "Blue" plans for medical practice.

Due to the shortage of time before the July 1, 1960, effective date of the act, he stated, negotiations were held at a rapid pace and the final contract with the federal Civil Service Commission had been submitted just two weeks earlier.

California Physicians' Service, Doctor Morrison said, had conducted a survey among its physician members as a means of determining their wishes as regards a contract for federal employees. He outlined some of the questions on the survey and told why the language of these questions had been used. The vote of physician members, he said, was seven to one in favor of servicing the proposed contract for federal employees.

Doctor Morrison also pointed out that the federal employees will each have a choice between four different types of medical care plans. The Blue Shield-Blue Cross type, represented by C.P.S., will be renegotiable periodically and inequities that appear may be adjusted.

In regard to medical foundations existing in some counties, Doctor Morrison reported that C.P.S. had agreed to provide insurance services for them under

the federal employees' program, so long as C.P.S. would not suffer financially. This attitude, he said, was based on a desire by C.P.S. to provide such services as physicians wished to provide for their patients on a sound basis.

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COMMITTEE ON MEDICAL SERVICES

A supplemental report of the Committee on Medical Services was made by Dr. Francis J. Cox, chairman. The report was published in full in the April, 1960, issue of CALIFORNIA MEDICINE, page 293.

ACTION ON RESOLUTIONS

The 1960 House of Delegates dealt with 82 resolutions, four of them emergency measures which were introduced at the final meeting of the House and voted upon without referral to a Reference Committee.

These resolutions are shown here in serial order and in the form in which they were acted upon, including amendments approved by the House of Delegates or substitute forms approved by the House.

In several instances the Reference Committees saw fit to combine several resolutions on the same topic and to submit a substitute resolution in place of all original proposals. Where this was done, the earliest numbered resolution is shown here as the one upon which action was taken, and the other resolutions combined with this are shown by reference further along the list.

* * *

"CALIFORNIA MEDICINE"

Resolution No. 1.

Author: Eugene S. Hopp.
Representing: San Francisco Medical Society.

WHEREAS, it is well recognized that CALIFORNIA MEDICINE is a most valuable and useful publication; and

WHEREAS, new members should serve on boards and committees for their own education and for the possible betterment of the board; and

WHEREAS, in more than ten years, of the forty-three members of the Editorial Board of CALIFORNIA MEDICINE, only nine have been replaced, and these only because of death or retirement from practice or illness; now, therefore, be it

Resolved: That the Council of the California Medical Association refer this to an appropriate committee to study the method of appointment of members of the Editorial Board of CALIFORNIA MEDICINE and to make recommendations for such methods of appointment and limitation of terms of service to five or ten years or whatever number of years would preserve best editorial policy and best serve the physicians of California.

ACTION: Adopted by House.

* * *

LEGAL REPRESENTATION DURING EXAMINATION

Resolution No. 2.

Author: Eugene M. Webb.
Representing: San Francisco Medical Society.

WHEREAS, the courts have decreed that patients being examined for the purpose of testimony are entitled to legal representation during the examination; and

WHEREAS, the presence of a third person basically interferes with a physician's capacity to evaluate his patient; and

WHEREAS, such a decree makes a mockery of the medical examination; now, therefore, be it

Resolved: That the House of Delegates instruct the C.M.A. Council to take any and all appropriate steps, in liaison with the State Bar Association, to remove this encumbrance.

ACTION: Adopted by House.

* * *

REGIONAL RELATIVE VALUE FACTORS

Resolution No. 3 (Regional Relative Value Factors) and Resolution No. 7 (Economic Trends and Locale) were combined by the C.P.S. Reference Committee into the following resolution:

Resolution No. 3.

Author: Karl L. Schaupp, Jr.
Representing: San Francisco Medical Society.

Resolved: That future contracts made by C.P.S. should be based on the Relative Value Study; and be it further

Resolved: That C.P.S. should investigate the feasibility of applying different unit values to reflect prevailing rates in various localities.

ACTION: Adopted by House.

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ANNUAL MEETING DATES

Resolutions No. 4 and 32 were combined by Reference Committee No. 3 and the following substitute adopted:

Resolution No. 4.

Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, the House of Delegates by unanimous vote in 1959 requested of the Council that the annual session of the C.M.A. be returned as nearly as

possible to its usual meeting date, believing that the February date precludes the possibility of adequate preparation by delegations for the meeting; now, therefore, be it

Resolved: That the Annual Session of the California Medical Association shall occur between the 15th of March and the 15th of April of each year. The time, place and exact dates of the meeting shall be determined by the Council five years in advance and announced to the House of Delegates at the second meeting at each Annual Session.

ACTION: Adopted by House.

* * *

PSYCHIATRIC COVERAGE

Resolution No. 5.

Author: Charles W. Leach.
Representing: San Francisco Medical Society.

WHEREAS, medical coverage of psychiatric cases is not provided by C.P.S.; and

WHEREAS, this would be desirable both for patients and their physicians; now, therefore, be it

Resolved: That C.P.S. should continue its study of the feasibility of providing inpatient psychiatric coverage for acute psychiatric emergencies, and provide such coverage when it is actuarially sound.

ACTION: Adopted by House.

* * *

C.P.S. HOME CARE

Resolution No. 6.

Author: Charles W. Leach.
Representing: San Francisco Medical Society.

WHEREAS, in order to cut down on hospital costs and accusations of overuse . . . (especially for patients who have no one at home to care for them and must stay over long in a hospital), and

WHEREAS, C.P.S. does not provide this type of service; now, therefore, be it

Resolved: That C.P.S. provide home nursing, or convalescent, or home makers service, or home medical care and thus save money by caring for patients who otherwise would by necessity require prolonged, extensive hospitalization.

ACTION: Referred to Commission on Medical Services, Liaison Committee to C.P.S.

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Resolution No. 7—See Resolution No. 3.

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RADIODIAGNOSTIC CONSULTATIVE SERVICES

The C.P.S. Reference Committee determined that Resolution No. 8 and Resolution No. 22 were almost identical; the committee offered an amendment to one portion of both resolutions, to make them identical, and proposed the following:

Resolution No. 8.

Author: L. Henry Garland.
Representing: San Francisco Medical Society.

WHEREAS, the Federal civil service employees' health insurance programs will encompass a significant proportion of the practicing physicians' patient load; and

WHEREAS, the benefits to be received under these programs will be decided in part by physicians serving on the boards of bodies such as commercial health insurance carriers, California Physicians' Service and the like; and

WHEREAS, many voluntary health insurance programs do not provide realistic radiotherapy benefits, and do not provide radiodiagnostic consultative allowances; now, therefore, be it

Resolved: That this House suggest that governing bodies of California Physicians' Service and comparable health insurance groups provide adequate roentgen diagnostic consultative allowance, and radiation therapy benefits which will allow optimum treatment of the patient; and be it further

Resolved: That copies of this resolution be forwarded to California Physicians' Service, the Blue Cross organizations in this state and other appropriate bodies involved in the civil service employee's health insurance program.

ACTION: Adopted by House.

* * *

AMBULANCE DRIVERS TRAINING

Resolution No. 9.

Author: Delegates of the First District.
Representing: First C.M.A. District.

WHEREAS, Section 21714 of the California Vehicle Code has been enacted into law requiring ambulance drivers and attendants to be properly trained in first aid; and

WHEREAS, physicians recognize that good first aid at the scene of an accident, before the patient is moved, can be of utmost importance; and

WHEREAS, several county medical societies in California already have established effective training courses for ambulance personnel; now, therefore, be it

Resolved: That the Council of the California Medical Association be instructed to assist each county medical society in establishing a training course for ambulance drivers and attendants in cooperation with local chapters of the American Red Cross or the United States Bureau of Mines, or other qualified groups concerned with this subject.

ACTION: Adopted by House.

ANESTHESIOLOGISTS' FEES

Resolution No. 10.

Author: Carl E. Anderson.

Representing: Sonoma County Medical Society.

WHEREAS, the California Physicians' Service "B" Schedule has generally been accepted in this county for doctors' fees for patients with an income up to $6,000.00; and

WHEREAS, the fees provided for anesthesiologists under said Schedule are inadequate in relation to surgical and other fees under said schedule; and

WHEREAS, many anesthesiologists have resigned from California Physicians' Service because of these inequities; and

WHEREAS, anesthesiologists have accepted a $4.00 unit based on the California Medical Association's Relative Value Study for low income groups under programs sponsored by Foundations and other plans; now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association instruct California Physicians' Service to review and establish anesthesiologists' fees in conformity with the Relative Value Study of the California Medical Association on an equitable basis.

ACTION: Adopted by House.

C.P.S. FEES FOR ASSISTANT SURGEONS

The C.P.S. Reference Committee considered Resolutions No. 11 and No. 12 together and offered the following substitute in lieu of both:

Resolution No. 11.

Author: W. H. Brignoli.

Representing: Napa County Medical Society.

Resolved: That the House of Delegates of the California Medical Association instruct California Physicians' Service to review and establish assistant surgeons' fees in conformity with the Relative Value Study of the California Medical Association on an equitable unit basis.

ACTION: Adopted by House.

Resolution No. 12—See Resolution No. 11, above.

CALIFORNIA PHYSICIANS' SERVICE

Resolution No. 13.

Author: Harold Batzle.

Representing: Riverside County Medical Association.

Resolved: That, believing that California Physicians' Service Schedule "A" contract is no longer practical for either the patient or the physician, and that because of this inadequacy this contract is now contributing to the irritation of all concerned, this House of Delegates recommends to the Trustees of California Physicians' Service that "Schedule A" be now formally abolished except for elderly retired people with incomes under $4,200, students and similar low income groups, and all groups now having this schedule shall be converted to a more practical program before 1963; and be it further

Resolved: That the "A" schedule should be revised to remove present inequities.

ACTION: Referred to Commission on Medical Services, Liaison Committee to C.P.S.

CALIFORNIA PHYSICIANS' SERVICE

Resolution No. 14.

Author: Harold Batzle.

Representing: Riverside County Medical Association.

Resolved: (1) That the House of Delegates recommends to the Board of Trustees of California Physicians' Service that California Physicians' Service immediately develop a certainty of coverage (service) contract based upon the "usual fee" concept without income ceiling or fixed fee schedule; premiums to be computed on an actuarially sound basis in each instance and within each county wherein the component medical society undertakes to assume the responsibility for determining and operating under the "usual, customary and reasonable" fee principle.

(2) California Medical Association shall join with California Physicians' Service in a continuing and intensive research program to develop new and dynamic types of medical-hospital insurance programs which will provide the public with a selection of desirable coverages that at the same time provide the physician with freedom to practice without stagnating restrictions.

ACTION: Adopted by House.

RELATIVE VALUE STUDY

Resolution No. 15.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

COMPENSATION OF INTERNS, RESIDENTS

Resolution No. 16.

Author: Los Angeles County Medical Association delegation.

WHEREAS, the advances of Medical Science have made the adequate study of medicine an increasingly long and total time-consuming study; and

WHEREAS, the cost of providing and receiving this increasing knowledge becomes progressively greater; and

WHEREAS, the acquiring of a complete medical education defers for a considerable period economic compensation for the practice of medicine; and

WHEREAS, present fiscal and taxation policies of federal and local government make economic recovery from this financial attrition a difficult and long term struggle; now, therefore, be it

Resolved: That the California Medical Association undertake studies to determine, and action to implement a policy to achieve for interns and resident physicians a monetary compensation commensurate with the years of study, hours of work, and public benefit achieved by such individuals in all institutions approved for internship and residency training; and be it further

Resolved: That the C.M.A. Delegates to the A.M.A. be advised of such policy and instructed to put forth the utmost effort to make such a policy nation-wide in scope.

ACTION: Referred to Council.

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C.P.S. GOVERNMENT CONTRACTS

Resolution No. 17.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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C.P.S. POLICIES—UNIFORM DEDUCTIONS

Resolution No. 18.

Author: Lewis T. Bullock.

Representing: Los Angeles County Medical Association delegation.

WHEREAS, California Physicians' Service operates on a two visit deductible basis; and

WHEREAS, the cost of a visit to a doctor's office may vary widely, depending upon the character of the illness; and

WHEREAS, this variation in the amount the patient must pay is obviously unfair to a patient who happens to have an expensive initial visit; and

WHEREAS, this variation in the amount of coverage by policies with identical premiums is causing widespread dissatisfaction and criticism of C.P.S.; and

WHEREAS, such criticism of C.P.S. for unfair practices is harmful to the entire medical profession; and

WHEREAS, proper business and insurance principles require a uniform deduction on all policies with the same premium; therefore, be it

Resolved: That the California Physicians' Service be instructed to adopt a policy of making the amount to be deducted and paid by the patient the same on all policies of the same character and with the same premium.

ACTION: Adopted by House.

C.P.S. POLICY DECISIONS

Resolution No. 19.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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C.P.S. POLLS, SURVEYS, ETC.

Resolution No. 20.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

* * *

FEDERAL EMPLOYEES' INSURANCE

Resolution No. 21.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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Resolution No. 22—See Resolution No. 8.

Author: Los Angeles County Medical Association delegation.

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LEGISLATION RE: TISSUE RECORDS

Resolution No. 23.

Author: Los Angeles County Medical Association delegation.

WHEREAS, the purpose of Audit, Record and Tissue Committees of Hospital Staffs is to improve patient care; and

WHEREAS, other physicians' committees also exist to serve the public good; and

WHEREAS, in many instances the maximum benefit of such committees may be restricted because of the possibility of legal action resulting from such activities; now, therefore, be it

Resolved: That this House of Delegates of the C.M.A. urge the Commission on Public Policy of this Association to initiate legislation at the state level granting immunity from legal action for those transactions of doctors' committees acting in the public good.

ACTION: Referred to Council.

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CONTRACTUAL FEE AGREEMENTS

Resolution No. 24.

Author: Los Angeles County Medical Association delegation.

WHEREAS, it is the privilege and right of every individual doctor of medicine, after meeting the obligations imposed on him by state licensing law and the Principles of Medical Ethics, to decide for himself how he will practice his profession; and

WHEREAS, it is the privilege and right of every individual doctor of medicine to decide for himself whether or not to accept a fee offered as payment for his professional services; now, therefore, be it

Resolved: That the California Medical Association shall not contract with any person, firm or agency of any kind, with respect to the practice of medicine or to the fees for such practice, for any individual member or members of said association.

ACTION: Adopted by House.

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SOCIO-ECONOMIC PUBLICATION

Resolution No. 25.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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U.C.L.A. MEDICAL CENTER

Resolution No. 26.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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CONFLICT OF INTEREST

Resolution No. 27.

Author: Los Angeles County Medical Association delegation.

ACTION: Not adopted by House.

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SECTIONS—MEDICAL ECONOMICS

Resolution No. 28.

Author: William H. Thompson.
Representing: San Mateo County.

ACTION: Withdrawn by author.

* * *

SECTION CONVERSION FACTORS

Resolution No. 29.

Author: William H. Thompson.
Representing: San Mateo County.

WHEREAS, the basic principles as set forth in the Relative Value Study are sound; and

WHEREAS, private insurance companies, government agencies and California Physicians' Service continue to disregard the basic principle of nonuniformity of unit values between sections of the Relative Value Study; and

WHEREAS, disregard of this principle nullifies much of the value of the Relative Value Study and leads to certain inequities; now, therefore, be it

Resolved: That the California Medical Association make every effort to maintain this principle of nonuniformity of unit values between sections of the R.V.S. and not allow its subversion to an across-the-board unit value, particularly by C.P.S.; and be it further

Resolved: That the C.M.A., when authorized by this House of Delegates to use R.V.S. conversion factors in any negotiations, shall use only the individual conversion factors by sections.

ACTION: Adopted by House.

* * *

GEOGRAPHIC CONVERSION FACTORS

Resolution No. 30.

Author: William H. Thompson.
Representing: San Mateo County.

WHEREAS, the growth of private health insurance and the increasing use of tax funds for medical services has brought demands for state-wide uniform fee schedules; and

WHEREAS, medical services are purchased from individual physicians with wide variation in their cost of providing medical services; and

WHEREAS, it is therefore economically unfeasible for physicians of this state to abide by a single, statewide, uniform fee schedule; now, therefore, be it

Resolved: That the California Medical Association shall oppose the principle of state-wide uniform fee schedules; and be it further

Resolved: That the California Medical Association shall recognize geographic districts within which conversion factors shall be reported for the Relative Value Study and that only these conversion factors shall be used, when authorized by representatives of these districts, in negotiations with groups or agencies requesting information on the cost of medical services within this state.

ACTION: Adopted by House; referred to Commission on Medical Services.

* * *

C.P.S. CO-INSURANCE DEDUCTIBLES

Resolution No. 31.

Author: San Mateo delegation.

WHEREAS, C.P.S. does not now offer to the individual subscriber one, or several co-insurance deductible policies; and

WHEREAS, such policies are available through other insurance carriers to individuals as well as groups; and

WHEREAS, there appears to be a profound need for such coverage of individuals to permit treatment of serious illness where not several hundred, but several thousand dollars may be incurred in expenses; and

WHEREAS, such a deductible and co-insurance policy would diminish the frequency of procedures unnecessarily done in the hospital; and

WHEREAS, precedent has been set by other insurance carriers so that selling such a program to the public might be more feasible now than it was several years ago; now, therefore, be it

Resolved: That the C.M.A. direct the board of directors of C.P.S. to make another attempt to develop deductible policies and to offer on a pilot plan basis a choice of several such deductible plans such as $50, $100, or $150 deductible policy with a coinsurance payment of 10 to 25 per cent of the additional charges up to $5,000.

ACTION: Adopted by House.

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Resolution No. 32—See Resolution No. 4.

Author: San Mateo delegation.

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SOCIETY NAME CHANGE

Resolution No. 33.

Author: Frank H. O'Neil.

Representing: Humboldt County Medical Society.

WHEREAS, the component society of the California Medical Association which is designated by the charter name Humboldt County Medical Society is incorporated under the laws of California as the Humboldt-Del Norte County Medical Society; and

WHEREAS, the designated society represents the members of both Humboldt and Del Norte Counties; and

WHEREAS, the members of Del Norte County do not in the foreseeable future desire to establish a separate county society; and

WHEREAS, certain legal technical difficulties arise from time to time from the discrepancy between the incorporated name and the C.M.A. charter name of the society; now, therefore, be it

Resolved: That the C.M.A. charter name of the Humboldt County Medical Society be changed so as to read, Humboldt-Del Norte County Medical Society.

ACTION: Adopted by House.

* * *

HOUSE OF DELEGATES MEETINGS

Resolution No. 34.

Author: San Mateo County.

WHEREAS, the California Medical Association presents a valuable scientific program in connection with its annual meeting; and

WHEREAS, the House of Delegates is made up of physicians, many of whom wish to attend or participate in the scientific program; and

WHEREAS, the present meetings of the House of Delegates on Sunday and Wednesday not only crowd the necessary deliberative processes of the House of Delegates between its meetings, but also make it impossible for most members of the House to benefit from or contribute to the postgraduate courses, section meetings, and other scientific fare provided; now, therefore, be it

Resolved: That this House of Delegates hold its first meeting on Saturday at the hour of 2 p.m. The second half of this meeting is to start at 9:30 a.m. Sunday. The second meeting of the House of Delegates shall be held at 9:30 a.m. Wednesday.

ACTION: Adopted by House.

* * *

H.R. 4700—FORAND BILL

Resolution No. 35.

Author: J. Lafe Ludwig.

Representing: Los Angeles County Medical Association.

WHEREAS, there is now pending before the Congress of the United States, H.R. 4700, 86th Congress, the Forand Bill, which would amend the Social Security Act so as to provide a federally subsidized program of hospital, nursing home and surgical service for persons eligible for Old-Age, Survivors' and Disability Insurance benefits; and

WHEREAS, the need for this program for O.A.S.D.I. beneficiaries has not been clearly established; and

WHEREAS, this program would not help the medically indigent as most of them are not eligible for social security benefits; and

WHEREAS, the financing of this proposed program would result in prohibitive public taxation; and

WHEREAS, voluntary health insurance is making rapid progress in providing health insurance for our senior citizens with expanded coverage and broader protection; and

WHEREAS, medical care is not susceptible to production line techniques such as would inevitably follow if this program were adopted; and

WHEREAS, this program would subject the patient, the doctor, and the hospital to government regulation; and

WHEREAS, this program would take away from the individual, his right to solve his own medical problems and to think and act for himself with respect to these problems; and

WHEREAS, this program would be the first irreversible step toward nationalizing medicine in this country; and

WHEREAS, medicine has made tremendous strides in a society based on the free-enterprise system; now, therefore, be it

Resolved: That the California Medical Association hereby opposes the enactment of H.R. 4700, 86th Congress; and be it further

Resolved: That this resolution be communicated to the members of the Senate and House of Representatives of the United States from California, to the chairman of the Committee on Ways and Means of the House of Representatives and to the President of the United States.

ACTION: Adopted by House.

' ' '

HOUSE JOINT RESOLUTION NO. 23

Resolution No. 36.

Author: J. B. Price.
Representing: Orange County.

WHEREAS, America's greatness is the product of a people's faith in constitutional law designed to protect the property and enterprise of each citizen from political invasion and confiscation; and

WHEREAS, attacks upon this principle have produced hundreds of federal corporate activities in conflict with the individual enterprises of the American people; and

WHEREAS, these federal corporate activities which operate without constitutional authority have taken over 40 per cent of the land area and 20 per cent of the industrial capacity of the nation, and directly and indirectly consume more than half the federal revenue to pay their losses and hidden costs; and

WHEREAS, the intent and purpose of the 9th and 10th Amendments to the Constitution was to prohibit governmental exercise of powers not specifically delegated to government by it; and

WHEREAS, the Fifth Article of the Constitution provides the means by which the people can delegate powers to, or withhold powers from government through an Amendment process requiring concurrence by two-thirds of the members of both Houses of Congress, or by the application of the Legislatures of two-thirds of the states, and to be ratified by three-quarters of the states; and

WHEREAS, at the present time there is now pending in the House of Representatives House Joint Resolution No. 23, which has already been approved by the states of Wyoming and Texas, which provides that:

"Section 1. The Government of the United States shall not engage in any business, professional, commercial, financial, or industrial enterprise except as specified in the Constitution.

"Section 2. The Constitution or laws of any state, or the laws of the United States, shall not be subject to the terms of any foreign or domestic agreement which would abrogate this amendment.

"Section 3. The activities of the U. S. Government which violate the intent and purposes of this amendment shall, within a period of three years from the date of the ratification of this amendment, be liquidated and the properties and facilities affected shall be sold.

"Section 4. Three years after the ratification of this amendment the sixteenth article of amendments to the Constitution of the United States shall stand repealed and thereafter Congress shall not levy taxes on personal incomes, estates, and/or gifts."

Now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association go on record as approving and supporting House Joint Resolution No. 23; and be it further

Resolved: That a copy of this resolution be sent to members of both Houses of Congress from California and to members of the California State Legislature; and be it further

Resolved: That a similar type of resolution be presented by the California Medical Association Delegates to the American Medical Association House of Delegates for approval by that body.

ACTION: Referred to Council.

' ' '

HYPNOSIS

Resolution No. 37.

Author: J. E. Vaughan.
Representing: Kern County Medical Society.

WHEREAS, Hypnosis, an old medical tool, has been found recently to be very valuable in the treatment of many and varied disorders; and

WHEREAS, the use of Hypnosis for entertainment may cause physical as well as mental trauma to certain individuals; and

WHEREAS, the use of Hypnosis for entertainment degrades a useful medical tool; now, therefore, be it

Resolved: That the California Medical Association take a stand opposing the use of Hypnosis for entertainment purposes; and be it further

Resolved: That the California Medical Association shall encourage the introduction and passage of necessary legislation to prohibit this dangerous and improper use of Hypnosis.

ACTION: Referred to Council.

' ' '

ALTERNATE DELEGATES

Resolution No. 38.

Author: Santa Clara County delegation.
Representing: Santa Clara County.

WHEREAS, alternate delegates are rightly encouraged to fully participate in all phases of business

at county and district meetings as well as all other caucuses, but are incongruously segregated from their delegates on the floor of the House of Delegates; and

WHEREAS, it is believed that the intent of electing and sending alternate delegates to the regular sessions of the House of Delegates is to have them learn the important duties of a delegate by participation rather than by remote observation; and

WHEREAS, alternate delegates cannot adequately obtain proper training to eventually become responsible delegates unless they have the opportunity to constantly work at the sides of their delegates; now, therefore be it

Resolved: That alternate delegates be authorized to sit together with their delegates on the floor of the House of Delegates during the regular sessions.

ACTION: Adopted by House.

* * *

SMOG CONTROL

Resolution No. 39.

Author: C. G. Scarborough.

Representing: Santa Clara County Medical Society.

WHEREAS, "smog" is an increasing atmospheric problem in many of the more populous areas of California; and

WHEREAS, "smog" is a blot on our beautiful state obscuring its natural beauties and causing vast agricultural and industrial loss; and

WHEREAS, "smog" has conclusively been proven to be a health hazard attacking not only exposed nasal and ocular mucous membranes, but also aggravating pulmonary and bronchial disease present among our citizens; and

WHEREAS, improvement, at least in part, of most of the bronchopulmonary symptoms has been proven to be possible by isolation from "smog"; and

WHEREAS, such isolation is impossible, except by the use of highly expensive equipment facilities or by moving away from the urban areas; and

WHEREAS, such mass migration is impractical; and

WHEREAS, automotive exhausts with their atmospheric pollutants are among the major sources of "smog"; and

WHEREAS, experimental anti-"smog" exhaust devices are available; and

WHEREAS, use of such anti-"smog" devices on *all* automotive exhausts would practically eliminate this source of unhealthful "smog"; and

WHEREAS, more research and action along these lines is a health "must" for California; and

WHEREAS, the State Department of Public Health has now established maximum permissible air pollution standards; now, therefore, be it

Resolved: That the C.M.A. hereby recognizes the health hazards of "smog" and instructs the council to press for appropriate legislation aiming at limitation of air pollution, from whatever sources; and be it further

Resolved: That the members and Council of C.M.A. cooperate with the State Health Department in its efforts to control "smog" and with any Smog Control Agencies in their enforcement efforts.

ACTION: Adopted by House.

* * *

FALL-OUT SHELTERS

Resolution No. 40.

Author: Edward Liston.

Representing: Santa Clara County.

WHEREAS, there is no known defense against the direct effects of atomic bomb-strike; and

WHEREAS, very effective defense against the effects of blast, heat and fall-out radiation is possible; and

WHEREAS, the country with the highest percentage of survivors will be the so-called victor in any atomic conflict; and

WHEREAS, the efforts of the American people to provide for their personal survival have been negligible; and

WHEREAS, the public apathy is of great concern to the medical profession which has some appreciation of the consequences of an atomic holocaust; and

WHEREAS, while government has given endless warnings and excellent advice, it has given no concrete incentive to the public to provide fall-out shelters for their own protection; now, therefore, be it

Resolved: That the C.M.A. urges immediate legislation at all governmental levels which will provide strong economic motivation for the construction and maintenance of fall-out shelters.

Such legislation to provide:

1. All costs of construction and maintenance of approved shelters shall be deductible from the income tax of individuals and taxpaying organizations.

2. The full costs of construction of approved shelters shall be deducted from the tax appraised value of the property on which they are constructed.

3. Low interest loans shall be made available to individuals and organizations for the construction of such shelters.

4. The above incentives shall apply also to the remodeling or insulation against radiation of existing structures.

5. The above economic benefits shall not be denied because such shelters may be suitable for other purposes.

6. A special bonus shall be paid for specially constructed shelters which provide protection against atomic, bacteriological and chemical attack.

ACTION: Referred to Council.

* * *

COMPULSORY RETIREMENT

Resolution No. 41.

Author: Eugene M. Webb.

Representing: San Francisco Medical Society.

WHEREAS, compulsory retirement at the age of 65 precludes the desire and privilege of continuing employment, impairs physical and mental health, and impairs the economy; now, therefore, be it

Resolved: That the House of Delegates of the C.M.A. place itself on record as being opposed to the policy of compulsory retirement, and the Council be directed to take any and all appropriate steps to expedite such a position.

ACTION: Adopted by House.

* * *

C.M.A. POSTGRADUATE EDUCATION

Resolution No. 42.

Author: Edgar Wayburn.

Representing: San Francisco Medical Society.

WHEREAS, the present system of postgraduate education at C.M.A. conventions prevents the participation of the membership in both the scientific and business sessions of the C.M.A.; and

WHEREAS, the attendance and caliber of the scientific and business sessions should be increased in accord with the size and prestige of the C.M.A.; now, therefore, be it

Resolved: That the C.M.A. Committee on Scientific Work be requested NOT to schedule any postgraduate teaching courses during the annual C.M.A. session.

ACTION: Referred to ad hoc Committee on Scientific Activities.

* * *

COMMENDING DOCTOR WILBUR

Resolution No. 43.

Author: Charles W. Leach.

Representing: San Francisco Medical Society.

WHEREAS, it is well recognized that CALIFORNIA MEDICINE is a most valuable and useful publication; and

WHEREAS, its editorial standards have not been exceeded by any state medical journal; now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association present Dr. Dwight Wilbur, Editor of CALIFORNIA MEDICINE, with a Certificate of Distinguished Service to the C.M.A.

ACTION: Adopted by House.

* * *

WORLD MEDICAL ASSOCIATION

Resolution No. 44.

Author: Forrest M. Willett.

Representing: San Francisco Medical Society.

WHEREAS, the World Medical Association is the only international medical organization representing the practicing profession in the fields of medical socio-economics, medical science and medical education and devoted to protection of the freedom of practice of medicine; and

WHEREAS, funds from individual members are desperately needed to support this program; now, therefore, be it

Resolved: That the House of Delegates of the C.M.A. affirm its support of the World Medical Association and recommend that every member of the C.M.A. join the U. S. Committee of the World Medical Association; and be it further

Resolved: That the component county associations be urged to support and give official recognition to the officers and subcommittees of the U. S. Committee in order to achieve the objectives of the World Medical Association in protecting the freedom of medical practice and increasing the influence of the practicing medical profession at the international level

ACTION: Adopted by House.

* * *

HOSPITALIZATION FOR DIAGNOSIS

Resolution No. 45.

Author: Charles W. Leach.

Representing: San Francisco Medical Society.

WHEREAS, there are many acute and subacute medical problems which require prompt diagnosis; and

WHEREAS, many of these problems are best investigated in a hospital because of both time and safety factors; and

WHEREAS, such hospitalizations are frequently denied by C.P.S. because of an exclusion clause; now, therefore, be it

Resolved: That C.P.S. should study the possibility of providing hospitalization for diagnostic purposes at an appropriate premium.

ACTION: Adopted by House.

* * *

DIAGNOSTIC TESTS

Resolution No. 46.

Author: Charles W. Leach.
Representing: San Francisco Medical Society.

WHEREAS, patients are sometimes hospitalized for minor conditions to take advantage of C.P.S. coverage of procedures done in a hospital; and

WHEREAS, this constitutes a waste of hospital facilities and C.P.S. funds; now, therefore, be it

Resolved: That C.P.S. provide payment for necessary diagnostic tests and procedures whether done in or out of a hospital for those contracts not now covered.

ACTION: Adopted by House.

* * *

EARLY PAYMENT OF PREMIUMS

Resolution No. 47.

Author: Eugene M. Webb.
Representing: San Francisco Medical Society.

WHEREAS, the cost of hospital and medical care for the aged tends to be higher than for other groups; and

WHEREAS, the economic position of some of this group is relatively poor; now, therefore, be it

Resolved: That the House of Delegates of the C.M.A. urge leaders of industry, labor and insurance carriers to develop a countrywide health insurance plan, the premiums of which will be paid during working years and the benefits of which will remain in force after retirement, and that the C.M.A. delegates to the A.M.A. be instructed to present a similar resolution to A.M.A.

ACTION: Referred to Commission on Medical Services.

* * *

MEDIATION COMMITTEES

Resolution No. 48.

Author: Eugene S. Hopp.
Representing: San Francisco Medical Society.

WHEREAS, there has been confusion in the interpretation of the working of major medical expense (catastrophic) insurance policies; and

WHEREAS, this has led to misunderstandings among patients, physicians and insurance companies; and

WHEREAS, county medical societies have Insurance Mediation Committees for the specific purpose of arbitrating such matters; now, therefore, be it

Resolved: That the Council of the C.M.A. be directed to inform the Health Insurance Council of the existence of such committees and the desirability of referring these problems to them.

ACTION: Referred to Council.

* * *

PUBLIC HEALTH LEAGUE

Resolution No. 49.

Author: A. Justin Williams.
Representing: San Francisco Medical Society.

WHEREAS, the Public Health League is most effective in its work for the medical profession; and

WHEREAS, many physicians do not adequately support this fine organization; now, therefore, be it

Resolved: That the California Medical Association urge its component societies to cooperate with and to support the Public Health League.

ACTION: Adopted by House.

* * *

PUBLIC RELATIONS

Resolution No. 50.

Author: Malcolm S. M. Watts.
Representing: San Francisco Medical Society.

WHEREAS, many physicians believe and various studies have shown that the goals, purposes and accomplishments of the medical profession with regard to scientific, socio-economic and political developments in the field of medical care are poorly understood by the public; and

WHEREAS, greater public understanding and support are necessary if the best medical practice is to survive and continue to serve the public; and

WHEREAS, an effective public relations program is the best insurance that the purposes and performance of the medical profession will be understood and appreciated by the people of our state; now, therefore, be it

Resolved: That the C.M.A. activate its program to expand and accelerate public relations through the C.M.A. Public Relations Committee.

ACTION: Adopted by House.

* * *

C.P.S. MEDICAL COVERAGE

Resolution No. 51.

Author: Edgar Wayburn.
Representing: San Francisco Medical Society.

WHEREAS, the basic plans of coverage for C.P.S. were promulgated at its founding in 1938 and have

not been altered to any appreciable extent since then; and

WHEREAS, there are constant alterations in medical practice due to scientific advances; and

WHEREAS, different groups of medical specialists, including radiologists, anesthesiologists, psychiatrists and internists are urging that C.P.S. coverage be widened to keep pace with medicine's rapid changes; and

WHEREAS, C.P.S. properly should reflect these changes; now, therefore, be it

Resolved: That a committee be appointed to act as a liaison committee between the Medical Services Commission and C.P.S. and to review the medical coverage of C.P.S. contracts so that it can lead the way in furnishing the most medically advanced and adequate coverage as it did in its pioneer medical insurance; and be it further

Resolved: That this committee be empowered to make recommendations on all contracts and renewals, to be acted upon by the C.P.S. Board of Trustees, and to report annually to the House of Delegates.

ACTION: Adopted by House.

* * *

BLOOD FRACTIONS

Resolution No. 52.

Author: Robert L. Dennis.

Representing: Santa Clara County.

WHEREAS, the number of units of blood collected by any blood bank through a given period of time must be in excess of the number of units of blood used in order that a sufficient supply of the various groups and Rh types will be constantly at hand; and

WHEREAS, blood may be preserved for only 21 days from its date of drawing and then becomes outdated and useless as whole blood; and

WHEREAS, these unavoidable conditions render large quantities of blood useless unless the plasma is separated from the cell mass and is converted into usable fractions or is made fit to be preserved and used as whole plasma; and

WHEREAS, such outdated plasma must be sent to commercial laboratories either in the State of California or out of the state for necessary preparation and fractionation at considerable expense to the blood banks of origin and eventually to the people who will use such products; and

WHEREAS, most blood acquired by the blood banks has been given by the people without recompense at the request of the medical profession; and

WHEREAS, the members of the medical profession are keenly aware of the constantly rising cost of living and of services in all levels of life and strives to offer the best possible medical service at the lowest possible cost; now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association authorize and direct the Council of the California Medical Association to arrange for and cause to be performed a study of the feasibility of setting up a laboratory whereby all authorized blood banks in the State of California may have their outdated blood plasma treated or fractionated to the end that the products of outdated blood, including various testing sera, may be returned to the referring blood banks and be made available to the people at no cost other than the cost of its transportation and the services rendered in its preparation; and be it further

Resolved: That a report be given to this House of Delegates on its findings and recommendations in the above matter at its next annual session.

ACTION: Adopted by House.

* * *

NURSING SHORTAGE

Resolution No. 53.

Author: Leon P. Fox.

Representing: Santa Clara County.

WHEREAS, the shortage of registered nurses in California is appalling and progressive; and

WHEREAS, the Standard Hospital Diploma Schools, our best source of good bedside nurses, are diminishing in numbers; and

WHEREAS, the new collegiate degree programs have not yet proven their adequacy to replace the hospital school in quality or quantity; and

WHEREAS, the upgraded standards in nursing training have made educational costs in hospitals prohibitive; now, therefore, be it

Resolved: That the Council instruct the Committee on Other Professions to conduct an adequate survey of the Hospital Diploma Schools in California to determine if financial aid could preserve the remaining schools; and be it further

Resolved: That the possibility of establishing and sponsoring a Nursing Education Foundation, simulating the American Medical Education Foundation, be investigated; and be it further

Resolved: That the results of this survey and investigation be reported back to the House of Delegates of C.M.A. in 1961.

ACTION: Adopted by House.

REPORTING OF EPILEPSY

Resolution No. 54.

Author: Santa Clara delegation.

WHEREAS, epilepsy by law is reportable by physicians to the State of California Department of Public Health; and

WHEREAS, this reported information is automatically forwarded to the State Motor Vehicle Department, resulting in suspension of the epileptic's drivers' license, despite the fact that the report to the Health Department is made on forms titled: "*Confidential* Morbidity Report"; and

WHEREAS, the reporting of this condition is totally discriminatory, since no other illness, including alcoholism, resulting in loss or lapse of consciousness is reportable; and

WHEREAS, the reporting of this condition by the physician results in distrust of the physician by the patient, leading to loss of rapport and poor control of the patient's spells and thereby to greater hazard to the patient and society on or off the highways; and

WHEREAS, it seems reasonable and is ethical for the physician to report on the health of patients to the Motor Vehicle Department *only* with prior written authorization from the patients; and

WHEREAS, at the present time physicians are reluctant to report epilepsy; and

WHEREAS, it seems unjust to legally force physicians to initiate the exposure of patients' handicaps, the result of which leads to the patients being penalized, when it is evident that the Motor Vehicle Department could and should accomplish the same end without incriminating physicians as instigators of the process; now, therefore, be it

Resolved: That the Traffic Safety Committee of the California Medical Association be directed to undertake a study of methods and to develop proposals whereby all medical conditions, including epilepsy, resulting in potential inadequate control of motor vehicles can be dealt with administratively on an equitable, nondiscriminatory basis for the purpose of improving safety conditions on California highways; and be it further

Resolved: That the C.M.A. Council take steps to make it mandatory that the Motor Vehicle Department obtain current specific authorizations from patients before having access to confidential medically reported conditions.

ACTION: Adopted by House.

POSTGRADUATE EDUCATION

Resolution No. 55.

Author: Carl E. Anderson.

Representing: Sonoma County.

WHEREAS, a recently vacated Medical Educational Institution and Teaching Hospital is now in progress of redevelopment in San Francisco; and

WHEREAS, the nonprofit philanthropic agency now in tenancy has publicly announced the intention to develop a program of Postgraduate Education and other Public Medical Services; and

WHEREAS, Postgraduate Medical Education and Para-medical Personnel Training Programs are a primary responsibility of organized medicine to foster and perpetuate; and

WHEREAS, these two projects will require both financial and consultative assistance for widest and most effective development through the efforts of the Committee on Postgraduate Activities and the officers and Council of the California Medical Association; now, therefore, be it

Resolved: That the House of Delegates of the California Medical Association in convention do assign and allocate funds sufficient for preliminary study and investigation of ways, means and mode of assisting these laudable and essential medical educational projects, thereby insuring an increasing supply of trained personnel and continuous provision for clinical technical advances through "in-hospital" and other medical postgraduate education.

ACTION: Referred to* ad hoc *Committee on Scientific Activities.

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WELFARE DRUG LIST

Resolution No. 56.

Author: Edward Liston.

Representing: Santa Clara County Medical Society.

WHEREAS, the drug list provided for the California Public Assistance Program for recipients of Old Age Security and Aid to the Blind is inadequate in the following respects:

1. It provides less than 50 drugs which might possibly be prescribed for use by mouth;

2. It provides less than 15 drugs which can be used by injection;

3. It prohibits commonly used combinations such as paregoric and bismuth or salicylates with codeine.

4. It provides some rarely used drugs and some drugs used for highly specialized purposes only but

provides almost none of the standard drugs used for the alleviation of the minor ills of the aging;

5. It provides:

a. No salicylates
b. No antihistamines
c. No laxatives
d. No lotions
e. No ointments
f. No antacids
g. No antipruritic
h. No potassium salt
i. No ammonium chloride
j. No suppositories
k. No cough mixture
l. No urinary antiseptic except gantrisin
m. No Dramamine or other similar drug
n. No pyridium or other similar drugs
o. No medication for preventive care of the skin
p. No barbiturates except phenobarbital and nembutal
q. No chloral or other nonbarbituratic hypnotics
r. No diabetic test supplies.

6. Its main effect is to reduce the cost of drugs to an absolute minimum inconsistent with the aims of the program which is to provide adequate medical care for the recipients; and

WHEREAS, In the public mind the cost of drugs is associated with the physicians' services; and

WHEREAS, The cost of drugs under OAS in indeed an important item and amounted to more than the cost of physicians' services provided under OAS; and

WHEREAS, a committee, in existence, has as its function the constant revision of the drug list and the solution of other problems relative to drugs; now, therefore, be it

Resolved: That the present difficulties outlined in the first *Whereas* be referred to the Liaison Committee to the State Department of Social Welfare for study and action; and be it further

Resolved: That attempts be made to disassociate in the minds of all concerned the cost of drugs from the cost of physicians' services under the OAS program.

ACTION: Adopted by House.

* * *

C.P.S. INCOME CEILING FEES

Resolution No. 57.

Author: Alameda-Contra Costa.

WHEREAS, the only statewide fee schedule available to California Physicians' Service for sale to large groups and industries which are statewide in location is the inadequate, outmoded and unrealistic "A" Schedule under the $4,200 income ceiling; and

WHEREAS, the absence of unified and decisive statewide instruction regarding a realistic fee level from California doctors to California Physicians' Service may jeopardize the participation of the profession and California Physicians' Service in the provision of health insurance benefits to Federal Employees in our state, and other statewide industries which purchase prepaid health plans; and

WHEREAS, California Physicians' Service must continue to be responsive to the needs of the public in the economics of medicine, as expressed through its close relationship to the doctors of California; and

WHEREAS, the leadership of California Physicians' Service in the provision of health insurance to California citizens in a manner prescribed by doctors results in the availability to the public of more adequate, more flexible, more comprehensive coverage from other insurance carriers; now, therefore, be it

Resolved: That this House instruct California Physicians' Service to provide to the public of California a statewide health insurance contract based upon the Relative Value Survey with a value of five dollars per unit, and with a family income ceiling of $7,200 per annum to enable C.P.S. to acquire approximately 10 per cent of the health insurance coverage in California and to remain a guiding influence in the development of prepayment health plans in this country.

ACTION: Referred to Commission on Medical Services, Liaison Committee to C.P.S.

* * *

INSURANCE PREMIUM TAX

Resolution No. 58.

Author: Alameda-Contra Costa.

WHEREAS, the State of California presently collects a premium tax of 2.35 per cent on health insurance premiums sold in California; and

WHEREAS, there is much public interest in making available to persons over age 65 health insurance at the most economical possible premium rate; now, therefore, be it

Resolved: That this House, through the Council of the C.M.A., urge the State of California to consider the public advantage to be derived from foregoing the premium tax on any health insurance policies sold by any insurance company to California residents over the age of 65.

ACTION: Adopted by House.

HEALTH INSURANCE FOR ELDERLY

Resolution No. 59.

Author: Alameda-Contra Costa.

WHEREAS, direct purchase of health insurance from private insurance carriers, Blue Shield and Blue Cross, would provide a solution to the medical economic problems of elderly needy persons while fostering continued progress with no violent upheaval in current developments in health insurance; now, therefore, be it

Resolved: That the C.M.A. urge, that should the federal government see fit to appropriate additional funds for the health care of the needy elderly, that these funds be channeled into the purchase of prepaid health insurance from private carriers, Blue Shield and Blue Cross, and that these programs be utilized and designed with the leadership and guidance of the medical profession and distributed on a state and local level.

ACTION: Adopted by House.

* * *

RELATIVE VALUE SURVEY

Resolution No. 60.

Author: Alameda-Contra Costa.

WHEREAS, the California Medical Association's Relative Value Survey is widely used and accepted by insurance carriers, labor health and welfare plans and physicians as an instrument from which equitable and appropriate fee schedules can be developed; and

WHEREAS, the Relative Value concept has been recognized nationally as a pioneering step in medical economics; and

WHEREAS, the Relative Value Survey is of value to counties attempting to solve problems of medical economics; now, therefore, be it

Resolved: That this House continue to encourage the work of the committees concerned with the management and constant revision of the Relative Value Survey; and be it further

Resolved: That this House desires that the California Medical Association Council encourage production and distribution of the latest edition of the Relative Value Survey in the shortest possible time.

ACTION: Adopted by House.

* * *

INSTRUCTION OF HEALTH EDUCATORS

Resolution No. 61.

Author: Alameda-Contra Costa.

WHEREAS, the Education Code of the State of California *requires* that students in elementary schools shall receive instruction in "healthful living"; and

WHEREAS, the Education Code of the State of California *requires* as part of this "training in healthful living" instruction in accident prevention, public safety, fire prevention, and in the nature of alcohol and narcotics and their effects upon the human system; and

WHEREAS, all teachers at the elementary and secondary levels have additional responsibilities relating to the health of school children including general health instruction and activities concerned with health services; and

WHEREAS, research reveals that teachers in these areas are generally inadequately prepared to function effectively in the school health education program; now, therefore, be it

Resolved: That the C.M.A. recommends that those preparing to become teachers in the elementary and secondary schools be given appropriate material and instruction in the techniques of presenting health education; and be it further

Resolved: That the Council of the C.M.A., through the Committee on School Health, advise the State Superintendent of Instruction of our willingness to help in the preparation of this material.

ACTION: Adopted by House.

* * *

WORKMEN'S COMPENSATION

Resolution No. 62.

Author: Alameda-Contra Costa.

WHEREAS, it is apparent that in the administration of Workmen's Compensation there exists an emphasis on payment for injuries and disability as opposed to rehabilitation; and

WHEREAS, such emphasis creates problems in the speedy recovery of such patients; now, therefore, be it

Resolved: That the California Medical Association vigorously promote the concept that the funds expended under the Workmen's Compensation Act are most productive when used to defray the costs of maximum rehabilitation rather than to provide prolonged weekly payments for injuries and disability; that the California Medical Association instruct the Commission on Medical Services to study the problem for appropriate action.

ACTION: Adopted by House.

* * *

SENIOR CITIZENS

Resolution No. 63.

Author: Ian Macdonald.

ACTION: Not adopted by House.

C.P.S. LIMITATION

Resolution No. 64.

Author: E. H. Crane, Jr.

ACTION: Not adopted by House.

* * *

CODE OF INSURANCE STANDARDS

Resolution No. 65.

Author: August J. Haschka, Jr.

Representing: Los Angeles County Medical Association.

WHEREAS, mass subscription to prepaid health insurance programs has gained wide acceptance; and

WHEREAS, the insurance industry has become a major third party influence in the traditional relationship between patient and physicians; and

WHEREAS, health insurance programs vary widely in both their limits of coverage and in their accordance with the established principles and objectives of the medical profession; and

WHEREAS, some programs operate in the best interest of the policyholder, advance the general health standards of the community and are in harmony with the established principles and objectives of the medical profession; and

WHEREAS, other programs fail to operate in the best interest of the policyholder, lower the health standards of the community, violate the physician-patient relationship, conflict with the established principles and objectives of the medical profession, and tend to place the physician in a position of subordination to the insurance contract carrier; and

WHEREAS, policyholders often do not comprehend the technical limitations of their contracts, thereby leading to frequent misunderstanding and grievance between policyholder, contract carrier and the attending physician; and

WHEREAS, it is a proper function of the medical profession to be in a position to advise and guide the public in selecting sound medical insurance programs; now, therefore, be it

Resolved: That the Commission on Medical Services be instructed to study the feasibility of developing a code of medical and ethical standards which could serve as a basis for a continuing evaluation of all medical insurance programs sold in the State of California; and be it further

Resolved: That if this study shows such a code can be devised and that it will serve in the best interest of the public and medical profession, this committee will then formulate such a code of medical and ethical standards which, upon acceptance by the C.M.A. Council, will serve as a basis for evaluating all medical insurance programs voluntarily submitted to the California Medical Association for this purpose; and that this code and evaluation be employed by the California Medical Association and its component societies, upon its acceptance, in any manner compatible with the best interests of the public and the medical profession.

ACTION: Adopted by House.

* * *

NURSING STANDARDS

Resolution No. 66.

Author: J. Philip Sampson.

WHEREAS, the Committee on Other Professions now has members on the Advisory Council to the Board of Nurse Examiners, the Advisory Committee of the California Associate in Arts Nursing Project, the State Coordinating Committee on Nursing Education, the Committee on Evaluation of the Two-Year Program in Nursing; and

WHEREAS, this committee has met with the California State Nurses' Association, the National League for Nursing and the California League for Nursing, for the purpose of discussing programs of the Junior-Community College Education for Nursing; and

WHEREAS, this committee has recommended to the Advisory Council to the Board of Nurse Examiners that the highest legal standards of nurses' training be instituted in the two-year courses and that this standard of nurses' training and education be not lower than the present standards adopted by the Board and inasmuch as the Advisory Council adopted this recommendation unanimously; now, therefore, be it

Resolved: That the California Medical Association assure the Advisory Council to the Board of Nurse Examiners, the State Coordinating Committee on Nursing Education, the Advisory Committee of the California Associate in Arts Nursing Project, the Committee on Evaluation of the Two-Year Program in Nursing, that they are deeply concerned with the education and training of nurses and will support programs that raise the standards and practice of nursing in the State of California.

ACTION: Adopted by House.

* * *

PROFESSIONAL LIABILITY

Resolution No. 67.

Author: Malcolm C. Todd.

WHEREAS, the number of all type liability claims against the many professions licensed in the State of California have been increasing each year; and

WHEREAS, the judgment asked in professional liability claims against members of our profession becomes higher and higher; and

WHEREAS, every alleged case is not "Practice conducted in a careless, reckless and negligent manner"; and

WHEREAS, there is necessarily a difference between malpractice and "poor result"; now, therefore, be it

Resolved: That the California Medical Association instruct its legislative committee to work toward the introduction of Legislation in the State Assembly to the effect that plaintiff's attorneys must post $2,500 bond in order to file a professional liability suit in the State of California so as to cover fees, court costs, etc.

ACTION: Approved and referred to Liaison Committee to State Bar of California.

* * *

UNIT VALUE OF HOUSE CALLS

Resolution No. 68.

Author: Malcolm C. Todd.

WHEREAS, the California Medical Association is constantly striving for good public relations; and

WHEREAS, public relations are best maintained by close harmony between the patient and physician; and

WHEREAS, physician's house calls to the home of a patient will always be necessary for certain illnesses; and

WHEREAS, house calls are a service to the public and economically of nonprofitable value to the physician; and

WHEREAS, the Relative Value Study in the State of California allows only 1.5 units for a house call; now, therefore, be it

Resolved: That in order to prevent repeated small breaks in good public relations, the Relative Value scales of all approved C.M.A. programs provide for a minimum of two (2) units for each house call and three (3) units for each call after 11:00 p.m.

ACTION: Referred to Commission on Medical Services.

* * *

MENTAL ILLNESS LEGISLATION

Resolution No. 69.

Author: Donald D. Lum.

Representing: C.M.A. Council.

WHEREAS, Senate Constitutional Amendment Number Three introduced by Senator Dilworth on January 26, 1959, professes to protect the rights of mentally ill persons by providing for court action in every case of confinement for mental illness or mental deficiency; and

WHEREAS, this procedure puts such cases in the category of treatable illnesses; and

WHEREAS, the delay in therapy of such cases attendant upon this protracted legal process could jeopardize the safety and welfare of both the disturbed patient and other members of society; now, therefore, be it

Resolved: That the California Medical Association oppose the passage of this amendment and urge that a more reasonable and less hazardous procedure be developed for protection of the rights of the mentally ill with due consideration of the fact that existing legislation does in fact provide reasonable safeguards against injustice in such matters.

ACTION: Adopted by House.

* * *

SOCIAL SECURITY

Resolution No. 70.

Author: S. Fred Kaufman.

Representing: Santa Clara County.

WHEREAS, there is now pending in the Congress of the United States proposed legislation known as H.R. 10 (Keogh-Simpson Bill) to amend the tax laws to allow a measure of equality to the self-employed so that they may establish individual retirement programs similar to the tax plan that grants tax deferment and retirement benefits to employees of corporations; and

WHEREAS, the American Thrift Assembly is actively engaged in representing farm, small-business and professional self-employed to secure passage of this proposed legislation; now, therefore, be it

Resolved: That the California Medical Association recommends passage of the Keogh-Simpson Bill and actively endorses and helps to support the objectives of the American Thrift Assembly by appropriate financial assistance and with appropriate personnel assistance in such amounts and to such extent as deemed advisable by the Council of the C.M.A.

ACTION: Adopted by House.

* * *

RADIOTHERAPY BENEFITS

Resolution No. 71.

Author: Tenth District delegation.

WHEREAS, the federal civil service employees' health insurance programs will encompass a significant proportion of the practicing physicians' patient load; and

WHEREAS, the benefits to be received under these programs will be decided in part by physicians serving on the boards of bodies such as commercial health insurance carriers, California Physicians' Service and the like; and

WHEREAS, many voluntary health insurance programs do not provide realistic radiotherapy benefits, and do not provide radio-diagnostic consultative allowances; now, therefore, be it

Resolved: That this House requests that governing bodies of California Physicians' Service and comparable health insurance groups correct these deficiencies during the twelve-month period subsequent to the date of adoption of this resolution; and, be it further

Resolved: That copies of this resolution be forwarded to California Physicians' Service, the Blue Cross organizations in this state and other appropriate bodies involved in the civil service employees' health insurance program.

ACTION: Adopted by House.

* * *

UNMET MEDICAL CARE NEEDS

Resolution No. 72.

Author: Tenth District delegation.

WHEREAS, government direction and control of medical care is accomplished primarily through economic mechanisms; and

WHEREAS, purported or real unmet medical care needs are the prime instruments through which economic control of medicine is obtained; and

WHEREAS, the California Medical Association is the most logical organization to recognize and seek solutions of such unmet needs; and

WHEREAS, efforts by local medical societies and other groups to meet unmet medical needs on a local level have either failed or at least have been only partially successful, and, at the same time have created disunity within the profession and criticism from without; therefore, be it

Resolved: That the Bureau of Research and Planning or a committee designated by the C.M.A. Council be instructed to continue its efforts to the end that we will:

1. Organize and conduct research in the field of unmet medical needs in California.

2. Initiate research in the field of the marketing of medical care in an effort to establish new methods suitable to the needs discovered.

3. Recommend standards and principles applicable to such developed marketing methods (Foundation, co-insurance, etc.), acceptable to the C.M.A. House of Delegates.

ACTION: Adopted by House.

RELATIVE VALUE STUDY REVISION

Resolution No. 73.

Author: Robb Smith.

Representing: Fresno County.

WHEREAS, the Relative Value Study has proven to be a useful implement to individual physicians in the private practice of medicine; and

WHEREAS, it has been an equally forceful implement in various component county society health insurance activities, in particular the Foundation for Medical Care Programs; and

WHEREAS, it is desirable to have it up-to-date so as to reflect current medical methods and existing economic trends; therefore, be it

Resolved: That the Committee on Fees be directed to expedite their present study and revision of the Relative Value Study to provide members of the California Medical Association with a revised Relative Value Study reflecting current data.

ACTION: Adopted by House.

* * *

READING OF RESOLUTIONS

Resolution No. 74.

Author: Leon P. Fox.

Representing: Santa Clara County.

WHEREAS, the American Medical Association House of Delegates recognizes the reading of the "Resolve" portion of all resolutions on the floor of the House; and

WHEREAS, it is pertinent that all resolutions be given equal consideration prior to assignment to reference committees; and

WHEREAS, authors of resolutions should be given the privilege to personally identify themselves verbally and emphasize their viewpoints themselves, therefore, be it

Resolved: That the resolved portion of all resolutions be read on the floor of the House of Delegates and the author identified at the Annual Session if so requested by the author.

ACTION: Referred to Speaker of House of Delegates.

* * *

C.P.S. FEE SCHEDULES

Resolution No. 75.

Author: Clyde L. Boice.

Representing: Santa Clara County.

WHEREAS, C.P.S. fills an existing and future need in the field of voluntary health insurance; and

WHEREAS, C.P.S. must keep pace with an expanding and inflationary economy; and

WHEREAS, a service plan under the control of physicians is superior to health insurance sold by private companies, with no physician control; now, therefore, be it

Resolved: That C.P.S. be directed to study the feasibility of providing a "D" schedule, using the Relative Value Study with a conversion factor of $6.00, and having an $8,500 income ceiling.

ACTION: Referred to Commission on Medical Services, Liaison Committee to C.P.S.

* * *

C.P.S. CEILINGS

Resolution No. 76.

Author: George Houck.

Representing: Santa Clara County.

WHEREAS, approximately 30 per cent of the families in California have an income above $7,500 per year; and

WHEREAS, approximately 10 per cent of the families in California have an income above $10,000 per year; and

WHEREAS, the determination of this patient's "income ceiling" by the physician is frequently a source of patient dissatisfaction; and

WHEREAS, policies with an "income ceiling" have less appeal to the patient and are less salable; and

WHEREAS, the accounting resulting from inclusion of an "income ceiling" results in considerable administrative expense; therefore, be it

Resolved: That C.P.S. be directed to study the feasibility for possible future use of providing a schedule of insurance using the Relative Value Study with a conversion factor of 5.50 or more, with no exclusion on account of income.

ACTION: Referred to Commission on Medical Services, Liaison Committee to C.P.S.

* * *

PHYSICIANS' PLACEMENT SERVICE

Resolution No. 77.

Author: Carl Anderson.

Representing: Sonoma County.

WHEREAS, the California Medical Association has a responsibility in aiding new physicians who wish to locate in California; and

WHEREAS, the Placement Service of the California Medical Association has assisted hundreds of new physicians in finding locations where they are most needed; and

WHEREAS, this service, given without charge, is of great value to physicians looking for an association as well as physicians who need an associate in their practice; therefore, be it

Resolved: That the House of Delegates of the California Medical Association commend the Physician Placement Service for its activities and encourage its further development.

ACTION: Adopted by House.

* * *

SOCIO-ECONOMIC POLICY

Resolution No. 78.

Author: L. A. Alesen.

Representing: Los Angeles County.

ACTION: Not adopted by House.

* * *

In addition to the numbered resolutions, the House of Delegates received four emergency resolutions at its final meeting. All four were adopted by unanimous vote. They were as follows:

RETIRING OFFICERS

Author: John G. Morrison.

WHEREAS, Dr. T. Eric Reynolds has outspokenly defended the progress of medicine and the best interest of the public, furnishing to his colleagues leadership of the highest order, and wise counsel and unselfish sacrifice in office of trust and leadership in his county, state, and national medical associations; and

WHEREAS, Dr. Donald Lum has rendered to the doctors of California many years of imaginative and constructive leadership, and has in that time endeared himself to his colleagues everywhere for his good humor, his intelligence, his ready affability and friendship, his integrity and devotion to work in behalf of all doctors and the California Medical Association; and

WHEREAS, both of these distinguished members of the Alameda-Contra Costa Medical Association relinquish their offices of President of the California Medical Association and Chairman of the Council of the California Medical Association at the end of this session, to the regret of their friends and colleagues; now, therefore, be it

Resolved: That this House extends to Drs. Reynolds and Lum the appreciation of the members of the California Medical Association, and as an expression thereof this session of the California Medical Association House of Delegates, upon adjournment, declares this adjournment to be in honor of Drs. Reynolds and Lum.

* * *

A.M.A. DELEGATES

Author: Leon P. Fox.

WHEREAS, the House of Delegates of the American Medical Association is losing, by voluntary retirement, three of its most effective and dedicated delegates from C.M.A.; and

WHEREAS, these men have served long and well; therefore, be it

Resolved: That R. Stanley Kneeshaw of Santa Clara County, Cy Attwood of Alameda-Contra Costa County, and Don Cass of Los Angeles County be recognized by a standing ovation of this House.

DOCTOR FRANCIS J. COX

Author: Francis E. West, Past President.

WHEREAS, Dr. Francis J. Cox has contributed many years of devoted service to the advancement and betterment of the medical profession; and

WHEREAS, Dr. Cox has memorialized the California Medical Association by his leadership in the medico-economic field; and

WHEREAS, Dr. Cox is now voluntarily withdrawing from his position as Chairman of the Medical Services Commission of the C.M.A.; therefore, be it

Resolved: That Dr. Cox be thanked for his contributions by unanimous vote of this House of Delegates; and be it further

Resolved: That a copy of this resolution be appropriately inscribed and documented.

NEW MEDICAL SCHOOL

Author: Lewis T. Bullock.

WHEREAS, the population of California is rapidly expanding; and

WHEREAS, the number of physicians needed by the citizens will be progressively increasing; and

WHEREAS, the California Medical Association is devoted to the proposition that all citizens of California shall receive the best possible medical care; therefore, be it

Resolved: That the California Medical Association supports the development of another medical school in California.

BY-LAW AMENDMENTS

One proposed amendment to the Constitution of the California Medical Association and 16 proposed amendments to the By-Laws were dealt with by the 1960 House of Delegates.

The proposed Constitutional amendment failed to receive the required two-thirds vote. The following listing shows the By-Law amendments which were approved by the House or referred to the Council or other bodies for further study and recommendations.

BY-LAW AMENDMENT NO. 1

Author: Donald D. Lum.
Representing: The Council.

Be it Resolved: That Chapter VI, Section 7 of the By-Laws of this Association, California Medical Association, is hereby amended to increase the size of the Finance Committee from three (3) to five (5) so that said section shall hereafter read as follows:

"Section 7.—Finance Committee of Council.

"The Chairman of the Council, subject to its approval, shall appoint a finance committee of five members, designating one of the members as its chairman, the duties of which committee are hereinafter specified."

ACTION: Approved by House.

BY-LAW AMENDMENT NO. 2

Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter X, Section 6, of the By-Laws be amended by deleting the second paragraph thereof and substituting therefor the following:

"The Finance Committee shall, by periodic inspection of accounts, bills and claims against the Association, and other items by means determined by it and approved by independent auditors, review all financial transactions of the Association and shall satisfy itself as to the validity of all withdrawals from depositaries approved by it. Checks or drafts drawn on Association accounts shall bear the signature of one or more authorized signers, as determined by the committee and approved by independent auditors, and all authorized signatories shall be covered by a surety bond."

ACTION: Approved by House.

BY-LAW AMENDMENT NO. 3

Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VIII, Section 6.5 of the By-Laws be amended by deleting from the second paragraph thereof the words shown below in parentheses and by adding the words shown below in italics, so that the paragraph shall read:

"At the first such caucus in each such district, the aggregate number of vacancies existing shall be divided into Offices No. 1, No. 2, et seq. with Offices Nos. 1, 4 and succeeding (multiples) *increments* of three carrying an initial term of one year and (then) thereafter terms of three years; with Offices Nos. 2, 5 and succeeding (multiples) *increments* of three carrying initial terms of two years and thereafter terms of three years; and with Offices Nos. 3, 6 and

succeeding (multiples) *increments* of three carrying initial terms of three years and thereafter terms of three years. *Where new Offices are created under the terms of Article III, Part B, Section 9(a) of the Constitution, each such new Office shall be numbered serially with those already existing and shall carry an initial term extending to the same date as has previously been established for Offices in the same numerical sequence, thereafter a term of three years.*"

ACTION: Approved by House.

' ' '

BY-LAW AMENDMENT NO. 4

Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VII, Section 1, Subsection (c) of the By-Laws of this Association, California Medical Association, is hereby amended to read as follows:

"(c) *Commission on Community Health Services,* responsible for the activities of and through which the following standing committees shall report:

"1. Committee on Rural Health,
"2. Committee on School Health,
"3. Committee on Industrial Health,
"4. Committee on Disaster Medical Care,
"5. Committee on Blood Banks,
"6. Committee on Allied Health Agencies,
"7. Committee on Traffic Safety."

ACTION: Approved by House.

' ' '

BY-LAW AMENDMENT NO. 5

Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VII, Section 1, Subsection (a) of the By-Laws of this Association, California Medical Association, is hereby amended to read as follows:

"(a) *Commission on Medical Services,* responsible for the activities of and through which the following standing committees shall report:

"1. Committee on Fees,
"2. Committee on Aging,
"3. Committee on Government Financed Medical Care,
"4. Committee on Rehabilitation."

ACTION: Approved by House.

' ' '

BY-LAW AMENDMENT NO. 6

Author: C. J. Attwood.
Representing: Constitution Study Committee.

Resolved: That Chapter III, Section 1, subsection (9), paragraph (a) be amended by deleting the final sentence of that paragraph, which reads: "A suspended member shall not be reinstated until he pays all dues accrued during the period of suspension."

ACTION: Approved by House.

' ' '

BY-LAW AMENDMENT NO. 7

Author: C. J. Attwood.
Representing: Constitution Study Committee.

Resolved: That Chapter III, Section 1, subsection (9), paragraph (a) be amended by adding to the third sentence of that paragraph the words shown in italics below, so that the sentence would read: "The Judicial Commission at the end of the suspended member's period of suspension shall consider the quality of his behavior during his suspension, and shall determine whether he shall be reinstated to membership in good standing or the period of suspension shall be extended; *provided that a suspension shall not extend beyond an aggregate period of five years.*"

ACTION: Approved by House.

' ' '

BY-LAW AMENDMENT NO. 8

Author: Los Angeles County Delegation.

WHEREAS, the aviation industry is one of the largest industries on the West Coast; and

WHEREAS, this rapidly growing industry presents many new medical problems; and

WHEREAS, these problems open the door to many new fields of medical research in connection with man's safe existence both on the ground and in the air, and in the future in outer space; and

WHEREAS, the present and projected future impact of aviation on medicine in general will have a definite effect on the medical interests of the public at large; now, therefore, be it

Resolved: That the By-Laws of the California Medical Association, Chapter IV, entitled "Sessions and Meetings; Scientific Sections, Section 1—Division of Scientific Work, Subsection a" be amended to hereafter read as follows:

"Subsection a, Scientific Sections:

"The scientific work of the Association shall be divided into nineteen scientific sections, as follows: Internal Medicine; General Surgery; Pediatrics; Ear, Nose and Throat; Urology; Anesthesiology; Obstetrics and Gynecology; Radiology; Industrial Medicine and Surgery; Aerospace Medicine; Pathology and Bacteriology; Dermatology and Syphilology; Neuropsychiatry; General Practice; Public

Health; Allergy; Eye; Orthopedics, and Physical Medicine.

ACTION: Referred to ad hoc Committee on Scientific Activities.

' ' '

BY-LAW AMENDMENT NO. 9

Author: Ian Macdonald.
Representing: Los Angeles County Delegation.

WHEREAS, the Trudeau Society of Los Angeles, the Chest Disease Section of the County Medical Society, at one of its regular meetings, voted that appropriate steps be taken toward the establishment of a Section on Diseases of the Chest in the California Medical Association; and

WHEREAS, the Council of the Los Angeles County Medical Association voted on September 14, 1959, that the Trudeau Society present such a resolution to the Los Angeles County Medical Association's delegation for presentation at the next meeting of the House of Delegates of the California Medical Association; now, therefore, be it

Resolved: That the By-Laws of the California Medical Association, Chapter IV, entitled "Sessions and Meetings; Scientific Sections, Section 1—Division of Scientific Work, Subsection a" be amended to hereafter read as follows:

"Subsection a, Scientific Sections:

"The scientific work of the Association shall be divided into nineteen scientific sections, as follows: Internal Medicine; General Surgery; Pediatrics; Ear, Nose and Throat; Urology; Anesthesiology; Obstetrics and Gynecology; Radiology; Industrial Medicine and Surgery; Diseases of the Chest; Pathology and Bacteriology; Dermatology and Syphilology; Neuropsychiatry; General Practice; Public Health; Allergy; Eye; Orthopedics, and Physical Medicine.

ACTION: Referred to ad hoc Committee on Scientific Activities.

' ' '

BY-LAW AMENDMENT NO. 10

Author: San Francisco Delegation.

Resolved: That the By-Laws be amended by the deletion of Section 12, Chapter V, which reads:

"The Committee on Credentials shall require each delegate and alternate who desires to be seated as a member of the House of Delegates, to subscribe to the oath or affirmation in the form required for officers under Section 3 of Chapter XIII. In the event of refusal to subscribe to such oath, the Credentials Committee may at its discretion refuse to include such person in its written report to the House of Delegates designating the delegates and alternates entitled to membership therein. Any person refused a seat by action of the Credentials Committee shall have the right to appeal to the House and by majority vote the House may overrule the Credentials Committee and seat such person as a delegate."

ACTION: Referred to Council for study of all oaths.

' ' '

BY-LAW AMENDMENT NO. 11

Author: San Francisco Delegation.

Resolved: That the By-Laws be amended by the deletion of Section 3, Chapter XIII, which reads:

"All officers and employees of the Association, upon election or appointment, shall subscribe to an oath or affirmation as follows: 'I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U.S.A. by violent or unlawful means, nor do I belong or have belonged to any organization while it was listed, published or held to be subversive by the Department of Justice of the United States of America.' If, after full hearing the Council shall find that an officer or employee falsely subscribed to the oath or affirmation, it may in its discretion remove the officer or employee from his office or position and fill the vacancy so created."

ACTION: Referred to Council for study of all oaths.

' ' '

BY-LAW AMENDMENT NO. 12

Author: Douglas G. Campbell.
Representing: San Francisco County.

WHEREAS, in 1949 it was voted that there be a By-Laws amendment to change the name of the Section on Neuropsychiatry to the Section on Psychiatry and Neurology, but this change was inadvertently omitted in the new Constitution; now, therefore, be it

Resolved: That the By-Laws of the California Medical Association, Chapter IV, entitled "Sessions and Meetings; Scientific Sections, Section 1—Division of Scientific Work, Subsection a" be amended to hereafter read as follows:

"Subsection a, Scientific Sections:

"The scientific work of the Association shall be divided into eighteen scientific sections, as follows: Internal Medicine; General Surgery; Pediatrics; Ear, Nose and Throat; Urology; Anesthesiology; Obstetrics and Gynecology; Radiology; Industrial Medicine and Surgery; Pathology and Bacteriology; Dermatology and Syphilology; *Psychiatry and Neu-*

rology; General Practice; Public Health; Allergy; Eye; Orthopedics; and Physical Medicine."

ACTION: Approved by House.

* * *

BY-LAW AMENDMENT NO. 13

Author: Wells G. Cook.
Representing: Los Angeles County.

Resolved: That Chapter IV, Section 1, subsection (a) of the By-Laws be amended by inserting the words "Preventive Medicine and" before the words "Public Health" so that this scientific section shall become the Section on Preventive Medicine and Public Health.

ACTION: Referred to Council for study.

* * *

BY-LAW AMENDMENT NO. 14

Author: Donald D. Lum.
Representing: The Council.

Resolved: That Chapter VII, Section 1, subsection (f) of the By-Laws be amended by deleting the period at the end of the section, by substituting therefor a comma and by adding the following language (new language shown in italics) *through which the following standing committees shall report:*

1. Committee on Cancer Education,
2. Committee on Tumor Tissue Registry,
3. Committee on Consultative Tumor Boards,
4. Committee on Special Cancer Problems,
5. Committee on New and Unproved Methods of Cancer Treatment.

ACTION: Approved by House.

* * *

BY-LAW AMENDMENT NO. 15

Author: Alameda-Contra Costa Delegation.

Resolved: That should By-Law Resolution No. 7 be adopted, Chapter III, Section 1, subsection (9), paragraph (a), be further amended by adding the following sentence: "The decision of the Judicial Council to reinstate to membership or to extend the suspension of a member, may be expressed in resolution adopted by vote according to subsection (8) and shall be sent to the Secretary of the Society for distribution pursuant to subsection (10) (a)."

ACTION: Approved by House.

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BY-LAW AMENDMENT NO. 16

Author: Douglas Donath.

ACTION: Not approved by House.

CONSTITUTIONAL AMENDMENT

One proposed amendment to the Constitution of the California Medical Association was introduced in the 1960 House of Delegates. In accordance with requirements of the Constitution, this proposed amendment must lie on the table for one year, during which time it must be published in two issues of CALIFORNIA MEDICINE.

In the 1961 House of Delegates, this proposed amendment will be reviewed by a Reference Committee and reported back to the House of Delegates with the recommendation of that committee for approval or disapproval.

Proposed amendments to the Constitution may not be amended following their introduction but are voted on in the form in which they are introduced. A two-thirds affirmative vote in the House of Delegates is required for passage.

Author: C. J. Attwood.
Representing: Constitution Study Committee.

Resolved: That Article VIII, Section 3, of the Constitution be amended by deleting the final paragraph of the section, starting with the words "Further, such proposed amendment . . ." and concluding with the words "prior to submission to the House of Delegates for vote." and substituting therefor the following:

"Further, such proposed amendment or amendments shall be referred to the appropriate reference committee, which shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention.

"If the proposal or proposals are introduced during the first meeting of the House, hearings shall be held at both the current and the next regular session. In this event, the reference committee shall report at a subsequent meeting of the House at the current session its findings and recommendations on the proposed amendment or amendments; this report shall be solely for the guidance of the reference committee and the House at the regular session at which the amendment or amendments are to be subject to vote. The reference committee at the current session may, with the consent of the author of proposed amendment or amendments, alter, amend or modify the proposed amendment or amendments and offer such altered version at a later meeting during the current session, together with its recommendations thereon.

"If the proposal or proposals are introduced during the second meeting of the House, hearings on them shall be held at the next regular session, prior to their submission to the House of Delegates for vote."

Council Meeting Minutes

Tentative Draft: Minutes of the 458th Meeting of the Council, San Francisco, St. Francis Hotel, March 26, 1960.

The meeting was called to order by Chairman Sherman in the Borgia Room of the St. Francis Hotel, San Francisco, on Saturday, March 26, 1960, at 9:30 a.m.

Roll Call:

Present were President Foster, President-Elect Bostick, Speaker Doyle, Vice-Speaker Heron, Secretary Hosmer, Editor Wilbur and Councilors MacLaggan, Wheeler, Todd, Quinn, O'Neill, Kirchner, O'Connor, Shaw, Rogers, Gifford, Murray, Davis, Miller, Sherman, Campbell, Morrison, Anderson and Teall. None absent.

A quorum present and acting.

Present by invitation were Messrs. Hunton, Thomas, Clancy, Collins, Marvin, Whelan, Edwards and Dr. Batchelder of C.M.A. staff; Messrs. Hassard and Huber of legal counsel; county executives Scheuber of Alameda-Contra Costa, Jensen of Fresno, Pettis and Field of Los Angeles, Bannister of Orange, Brayer of Riverside, Dochtermann of Sacramento, Donmyer of San Bernardino, Nute of San Diego, Neick of San Francisco, Thompson of San Joaquin, Donovan of Santa Clara and Bailey of Tulare; Dr. Malcolm Merrill, state Director of Public Health, Dr. John Keye of the State Department of Social Welfare; Dr. A. E. Larsen and Messrs. Wilson Wahlberg, Martin Webb and Richard Lyon of California Physicians' Service; Mr. Charles O. Finley; Doctors Roberta Fenlon, Thomas Elmendorf, W. W. Stiles, John Schaupp, George Herzog, Homer Pheasant and others.

1. *Minutes for Approval:*

(a) On motion duly made and seconded, minutes of the 456th meeting of the Council, held February 20-24, 1960, were approved.

(b) On motion duly made and seconded, minutes of the 457th meeting of the Council, held February 24, 1960, were approved.

2. *Membership:*

(a) A report of membership as of March 24, 1960, was presented and ordered filed.

(b) On motion duly made and seconded in each instance, ten applicants were voted Retired Membership. These were: Frederick J. Carson, James Hilgesen, Alameda-Contra Costa County; Arthur M. Rosenthal, R. Esmond Smith, Leon J. Tiber, Leland S. Welbourn, Los Angeles County; Adolph Gottschalk, Albert M. Jacobs, S. Nicholas Jacobs, San Francisco County; Henry D. Stailey, Sonoma County.

(c) On motion duly made and seconded in each instance, 17 applicants were voted Associate Membership. These were: Carl V. Granger, Jr., Marin County; Richard H. Anderson, Amet El Aziz Zahawi, Orange County; Ross H. Seasly, Jr., San Bernardino County; Mary Bradford, Charles R. Cotham, San Diego County; Alfred L. Kavanagh, San Joaquin County; Joseph W. Galla, San Mateo County; Amalie Jacobsohn, Merrill Hubert Judd, Edward William McCormick, Antipas Merjanian, William Matthew Sproul, Gerald W. Turley, Neil Flaherty, Tokio Ishikawa, Milton Veldee, Santa Clara County.

(d) On motion duly made and seconded in each instance, reductions of dues were voted for 19 members for reasons of prolonged illness or postgraduate study.

(e) Applications for reductions of dues for other reasons were presented and referred to the Finance Committee for study and recommendation. On report of the committee, it was regularly moved, seconded and voted that these applications be denied and the applicants urged to resign their memberships temporarily and rejoin when they return to active practice in the county society area or elsewhere.

3. *1960 House of Delegates Actions:*

(a) *Recommendations of Reference Committee No. 1:*

Reports of District Councilors—Recommended these be circulated in the districts and not published in Pre-Convention Bulletin: It was agreed that district councilors consider the procedure in use in some districts, where regular reports are made following Council meetings, such reports prepared by the councilor and prepared and distributed to delegates through the C.M.A. office.

Committee on Disaster Medical Care—Recommended that county societies maintain strong and active local committees: Referred to Committee on Disaster Medical Care.

Committee on Community and Rural Health—Recommended continued studies of bracero problems: It was agreed to refer to committee, and that the committee give this high priority and keep county societies advised as to status of entire problem in C.M.A.

Commission on Medical Education—Re proposed committee on undergraduate activities: Refer to Committee on Medical Education for report to next Council meeting.

Commission on Medical Services—Urged publication of supplemental report in *Newsletter:* Agreed to publish in CALIFORNIA MEDICINE and publicize this publication in *Newsletter.*

Advertising Committee—Commend committee: Approved by Council for transmittal to committee members.

Social Security Poll Format—Refer back to committee: Agreed to refer back to committee, with suggestion that interested officers and councilors be invited to meet with committee. A specific group of councilors was designated to present the views of the Council to the committee.

(b) *Recommendations of Other Reference Committees:*

All resolutions adopted by the House of Delegates or specifically referred to the Council or to commissions or committees were reviewed. The following allocations or referrals were made, or affirmed, by the Council:

Referred to Council:

No. 16—Referred to Liaison Committee with California Hospital Association.

No. 23—Referred to Liaison Committee with California Hospital Association, Medical Review and Advisory Board and Legislative Committee.

No. 36—Tabled.

No. 37—Committee on Mental Health.

No. 40—Refer to Committee on Disaster Medical Care.

No. 48—Refer to Commission on Medical Services.

Referred to Commission on Medical Services (by action of House of Delegates or Council): Resolutions Nos. 30, 47, 48, 51, 59, 62, 65, 68, 73. (On No. 59, it was agreed that the Committee for Emergency Action could act if advisable.)

Referred to Liaison Committee between Commission on Medical Services and C.P.S.: Resolutions Nos. 6, 13, 57, 75, 76.

Referred to Board of Trustees of C.P.S.: Resolutions Nos. 3, 5, 7, 10, 11, 12, 14, 18, 29, 31, 45, 46.

Referred to Speaker of House of Delegates: Resolution No. 74.

Referred to Commission on Community Health Services: Resolution No. 9.

C.M.A. Staff to Implement—Resolutions Nos. 4, 8, 32, 33, 34, 35, 38, 41, 71.

Other Resolutions and Council Actions on Them:

No. 1—Committee on Scientific Work.

No. 2—Committee on Legislation.

No. 42—Ad hoc Committee on Scientific Activities.

No. 49—Publish in CALIFORNIA MEDICINE and in *Newsletter.*

No. 52—Finance Committee.

No. 53—Committee on Other Professions.

No. 54—First Resolved to Committee on Traffic Safety; second to Legislation.

No. 55—Ad hoc Committee on Scientific Activities.

No. 58—Committee on Legislation.

No. 61—Committee on School Health.

No. 66—Committee on Other Professions.

No. 67—Liaison Committee with State Bar.

No. 69—Committee on Legislation.

No. 70—Committee on Social Security Format.

No. 72—Bureau of Research and Planning.

By-Laws Amendments:

Nos. 8, 9, 13—Ad hoc Committee on Scientific Activities.

Nos. 10, 11—To legal counsel for opinion.

4. *Commission on Medical Services:*

Dr. Milo Youel of San Diego presented a suggested plan for the writing of medical cost insurance, utilizing a reserve and a loan fund for meeting costs. On motion duly made and seconded, it was voted to refer this to the Commission on Medical Services for study before referring it to the C.P.S. Board of Trustees.

Dr. Murray reported on the creation of an organization chart for the Commission—C.P.S. Liaison Committee and proposed several nominees for appointment to the committee. It was regularly moved, seconded and voted to refer these names to the Committee on Committees, with the Council to add one additional member and to designate a chairman.

On the liaison committee to the State Department of Social Welfare, Dr. Sherman expressed his wish to be relieved of the chairmanship and it was regularly moved, seconded and voted to appoint Dr. William Quinn as chairman.

On the advisory committee to the State Board of Social Welfare, the resignation of Dr. Harrington was received. Since the State Board has announced the necessity of reducing C.M.A. representation on this board to two members, it was regularly moved, seconded and voted to approve Doctors Sherman and Quinn as members.

A letter from a member, complaining of the choice of committee members under the Commission on Medical Services, was read to the Council. On motion duly made and seconded, it was voted to acknowledge receipt of this letter.

5. *Committee on Committees:*

Councilor Davis reported for his study committee that it was recommended that the Committee on Committees be made up of the President, President-Elect, Speaker, Council Chairman and five council-

ors who are not commission chairmen. It was also recommended that commission chairmen and others be invited to meet with the committee as consultants and that all meetings be in executive session. On motion duly made and seconded, these proposals were approved. On motion duly made and seconded, Councilors Gifford, Davis, Wheeler, Todd and Anderson were elected under the above committee structure.

On motion duly made and seconded, it was voted to refer to the Committee on Committees the matter of nominations for members of the Liaison Committee to the State Bar and the Advisory Committee to the California Medical Assistant's Association.

6. *California Medicine:*

Editor Wilbur proposed that a series of articles be run in CALIFORNIA MEDICINE to outline each aspect of the structure and activities of the Association, with the possibility that these articles might be incorporated in a pamphlet upon their completion. On motion duly made and seconded, this proposal was approved and it was voted to consider preparation of such a pamphlet for distribution to all new members of the Association after the articles had all been prepared and printed.

7. *Ad Hoc Committee on Scientific Activities:*

Dr. Wilbur gave a progress report for the Committee on Continuing Education and Scientific Activities, pointing out that subcommittees have been formed to consider, as separate items, CALIFORNIA MEDICINE, postgraduate activities and Annual Sessions. Further reports will be made later.

8. *Olympic Winter Games:*

Councilor Davis introduced Dr. W. W. Stiles, medical director of the Eighth Olympic Winter Games. Dr. Stiles reported that about 150 physicians had volunteered their services and that 58 had served, not more than 32 at any one time. All cases were handled effectively and about 2,500 patients were seen. Of these, roughly one-third were surgical cases, one-third upper respiratory cases and the balance miscellaneous medical problems. Dr. Stiles was complimented by the chairman for his good work.

9. *Financial:*

A report of bank balances, loans, etc., as of March 24, 1960, was presented and ordered filed.

Dr. Heron, chairman of the Finance Committee, recommended that an additional $1,000 be appropriated for the ad hoc Committee on Continuing Education and Scientific Activities. On motion duly made and seconded, this appropriation was voted by the required three-fourths vote. If additional funds are required in the next fiscal year, the committee will present its needs to the Council.

Dr. Heron also recommended that an additional $7,500 be appropriated for the purchase of equipment needed in the office. On motion duly made and seconded, this appropriation was voted by the required three-fourths vote.

On applications for reduction of dues for miscellaneous causes, the committee recommended that applicants be advised to resign temporarily and seek readmission when they return to active practice. (See also item 2e.)

10. *Reports of President, President-Elect:*

Doctors Foster and Bostick gave progress reports on their current activities. No action was required on either.

11. *Commission on Public Policy:*

(a) For the Committee on Legislation, Mr. Ben Read reported on the status of the current session of the State Legislature.

(b) For the Public Relations Committee, Dr. Watts reported on consideration given to an expanded program of public relations, including securing additional personnel for the department and for the Bureau of Research and Planning. On motion duly made and seconded, the Executive Director was authorized to secure needed personnel.

On motion duly made and seconded, it was voted to name the Council chairman, Finance Committee chairman and Public Relations chairman as a review committee to consider and approve matters of financing, personnel and other items in the public relations program.

Dr. Watts proposed that a steering committee be formed to prepare the programs for public relations conferences, with district councilors to choose members of this committee from among the public relations chairmen in their districts. On motion duly made and seconded, this proposal was approved.

On motion duly made and seconded, it was voted to authorize the Committee on Public Relations to establish a subcommittee on motion pictures, radio and television and, in conjunction with the Committee on Committees, to bring in nominations for this committee at the next Council meeting.

A question brought by members of the Commission on Cancer, asking clarification of the ethics of physicians sending followup examination letters to their patients, was discussed. It was agreed that such letters, if sent, should suggest a general examination rather than examination for a specific disease and that they should eliminate the possibility of the patient's being under the care of another physician. On motion duly made and seconded, it was voted that such letters under these circumstances would not be deemed unethical.

Mr. Clancy gave a progress report on a campaign directed against pending legislation considered inimical to the public health.

Mr. Clancy presented a proposed Certificate of Appreciation to be presented to the Kern County Medical Society in recognition of the services performed by members of the society following a disastrous train-truck wreck near Bakersfield. It was explained that such certificates might be prepared under unusual circumstances where individuals or groups, medical or lay, performed outstanding services in behalf of the public. On motion duly made and seconded, approval was voted for such certificates.

12. *State Department of Public Health:*

Dr. Malcolm Merrill, State Director of Public Health, gave a progress report on the work of the Department in fields of scientific research, narcotics and nalline testing, alcoholic rehabilitation, food additives, auto exhaust and air pollution. He also reported that the Hospital Council would meet April 1 to make final allocations of funds for aid in construction of hospitals and allied structures.

13. *California Physicians' Service:*

Dr. Heron reported that the stabilization fund of California Physicians' Service has almost reached the minimum requirements recommended by the NAIC and that C.P.S. programs are progressing satisfactorily.

14. *Committee on Insurance:*

Councilor Kirchner introduced Dr. Homer Pheasant, chairman of the Insurance Committee, and Mr. Charles O. Finley, administrator of the present disability insurance program. Dr. Pheasant commented on a financial report of the disability insurance program which had previously been distributed to Council members. Mr. Finley reported on a proposed program to be offered members of the American Medical Association to provide lifetime coverage for disabilities arising through either accident or illness, which several insurance carriers are prepared to underwrite.

On motion duly made and seconded, it was voted to extend the thanks of the Association to Mr. Finley for his conduct of the disability insurance program.

15. *Government Purchases of Medical Services:*

Dr. Teall discussed the very urgent need for doctors to clarify their thoughts on what they believe to be the proper role of government in medical care. He proposed a study to determine guide lines of philosophy and principle which C.M.A. can support as to (a) what medical services are the proper responsibility of government, (b) by which level of government, (federal, state, county, city) these services should be provided and (c) for which classes of citizens they should be provided. Since the subject concerns many C.M.A. committees and commissions it cannot be easily assigned to any one existing group for study and report. It was therefore, moved and passed that an ad hoc committee be requested to determine, and to recommend to the Council at its April meeting, how and by whom such a study can best be made. This ad hoc committee is to consist of the chairmen of the Commissions on Medical Service, on Public Agencies and on Public Policy and the chairman and members of the Bureau of Research and Planning. Dr. Sherman appointed the chairman of the Commission on Medical Services to chair this ad hoc recommending committee.

16. *Staff Report:*

Mr. Hassard directed attention to a report by California Physicians' Service on the MD-65 contracts, which to date have required no financial contribution by the Association.

Mr. Hassard also asked that the councilors review a set of suggested procedures for the Annual Session, drafted by the staff, and be prepared to decide on these questions at the next meeting.

Mr. Hassard also reported that within about ten days the final contract provisions for service and indemnity programs for federal employees would be announced. (In California, the service contract would provide for a unit factor of five on the Relative Value Study for employees or dependents up to a $7,200 income ceiling; the lower level of benefits would establish an income ceiling of $4,000 and benefits, on an indemnity basis only, of about factor three on the Relative Value Study.)

Adjournment:

There being no further business to come before it, the meeting was adjourned at 5:40 p.m.

SAMUEL R. SHERMAN, M.D., *Chairman*
MATTHEW N. HOSMER, M.D., *Secretary*

In Memoriam

BARKAN, HANS. Died in San Francisco, March 7, 1960, aged 77. Graduate of Harvard Medical School, Boston, Massachusetts, 1910. Licensed in California in 1914. Doctor Barkan was a retired member of the San Francisco Medical Society and the California Medical Association, and an associate member of the American Medical Association.

✤

BRANDON, THOMAS CAMPBELL. Died in San Jose, March 29, 1960, aged 50. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1935. Licensed in California in 1953. Doctor Brandon was a member of the Santa Clara County Medical Society.

✤

CHRISTENSEN, EUGENE L. Died in Covina, March 22, 1960, aged 62. Graduate of University of Minnesota Medical School, Minneapolis, 1924. Licensed in California in 1930. Doctor Christensen was a member of the Los Angeles County Medical Association.

✤

DOUGALL, JOHN PARK (J. PARK). Died in Los Angeles, March 31, 1960, aged 85. Graduate of California Eclectic Medical College, Los Angeles, 1904. Licensed in California in 1904. Doctor Dougall was a life member of the Los Angeles County Medical Association.

✤

HAENSZEL, ALLEN LEE. Died in San Bernardino, December 13, 1959, aged 74. Graduate of University of Buffalo School of Medicine, New York, 1908. Licensed in California in 1919. Doctor Haenszel was a member of the San Bernardino County Medical Society.

✤

LEGGE, ROBERT THOMAS. Died in Berkeley, March 21, 1960, aged 87, acute myocardial infarction with acute ventricular fibrillation. Graduate of University of California School of Medicine, Berkeley-San Francisco, 1899. Licensed in California in 1899. Doctor Legge was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

LEWIS, SILAS ARTHUR. Died in San Gabriel, February 18, 1960, aged 83. Graduate of State University of New York College of Medicine at New York City, Brooklyn, New York, 1910. Licensed in California in 1919. Doctor Lewis was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

MCCHESNEY, GEORGE JEWETT. Died in Mill Valley, March 11, 1960, aged 85. Graduate of University of California School of Medicine, Berkeley-San Francisco, 1900. Licensed in California in 1900. Doctor McChesney was a retired member of the San Francisco Medical Society and the California Medical Association, and an associate member of the American Medical Association.

✤

MCMARTIN, DAVID EDMOND. Died March 14, 1960, aged 37, of acute coronary occlusion. Graduate of University of Southern California School of Medicine, Los Angeles, 1946. Licensed in California in 1946. Doctor McMartin was a member of the Placer-Nevada-Sierra County Medical Society.

✤

MULVANY, THOMAS ANTHONY. Died March 26, 1960, aged 44. Graduate of Marquette University School of Medicine, Milwaukee, Wisconsin, 1943. Licensed in California in 1943. Doctor Mulvany was a member of the San Francisco Medical Society.

✤

OVIEDO, LOUIS JEROME. Died February 9, 1960, aged 62. Graduate of University of California School of Medicine, Berkeley-San Francisco, 1923. Licensed in California in 1923. Doctor Oviedo was a member of the Yolo County Medical Society.

✤

SELTZER, SOL NORRIS. Died December 29, 1959, aged 49. Graduate of Wayne State University College of Medicine, Detroit, Michigan, 1937. Licensed in California in 1946. Doctor Seltzer was a member of the San Bernardino County Medical Society.

✤

SUTHERLAND, ROBERT THOMAS. Died February 17, 1960, aged 76, of atherosclerotic heart disease. Graduate of University of California School of Medicine, Berkeley-San Francisco, 1908. Licensed in California in 1908. Doctor Sutherland was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

CORRECTION

Data on San Bernardino County was inadvertently omitted from Table 2 of the article, "The Number and Distribution of Physicians in California," by Justin J. Stein, M.D., which appeared in the March issue of CALIFORNIA MEDICINE.

The missing data are supplied herewith:

TABLE 2.—*Table Showing Ratio of Physicians to Population*

County	Population		Licensed Physicians, M.D.		Licensed Physicians, D.O.		Total		No. of Persons Per Physician	
	7/1/54	7/1/58	3/2/55	3/2/58	10/1/54	6/1/58	1955	1958	1955	1958
San Bernardino.....	362,700	470,500	397	499	41	49	438	548	828	859

PUBLIC HEALTH REPORT

MALCOLM H. MERRILL, *M.D., M.P.H.*
Director, State Department of Public Health

REGULATIONS GOVERNING the registration of possessors of sources of ionizing radiation were adopted April 22 by the State Board of Public Health as a requirement of a new state law adopted by the Legislature in its 1959 session.

Purpose of the legislation is to provide information relating to the amounts, kinds and uses of sources of radiation in California. The data collected through registration will be useful in evaluating potential hazards, in estimating the magnitude of the population's exposure to radiation, and in encouraging the development of peacetime uses of atomic energy and radiation consistent with requirements for health and safety.

The regulations, which will go into effect May 22, include:

1. Persons with x-ray or fluoroscopic machines, radioactive materials, particle accelerators, reactors, devices containing radioisotopes and any other sources of ionizing radiation must register before July 31. Excluded from registration are small amounts of some types of radioactive materials. A complete list of exclusions can be obtained upon request from the department's Bureau of Radiological Health, 2151 Berkeley Way, Berkeley.

2. Anyone acquiring a radiation source after June 30 must register within 30 days of the date of acquisition.

3. It is the responsibility of each possessor of a radiation source to obtain and submit the necessary registration forms.

Forms and instructions will be mailed to most persons believed to have sources of radiation, including physicians, dentists, osteopaths, chiropractors, chiropodists, veterinarians and hospitals, as well as persons with specific licenses issued by the Atomic Energy Commission.

Plans are under way with some local health departments for them to participate in the registration program.

* * *

A leaflet giving the signs and symptoms of syphilis and gonorrhea has just been published by the State Health Department for use with Spanish-speaking persons in California who have difficulty reading English. The text on the top part of each page is written in Spanish, and is repeated on the lower part in simple English.

In addition to giving the signs and symptoms of gonorrhea and syphilis, it discusses the way these diseases are spread, and stresses the importance of going to a physician if signs of venereal disease are present.

This pocket-sized leaflet, titled *Peligro! Danger!*, can be obtained through local health departments.

* * *

Phenylketonuria, a disease which causes permanent mental retardation if not diagnosed soon after birth, is being successfully prevented in California with a special, synthetic diet supplied by this department in certain cases.

The disease, which develops within six weeks after birth, is caused by congenital inability to metabolize the essential amino acid *phenylalanine*. It can be prevented if diagnosis is made early and the child is placed on a low phenylalanine diet.

With a grant from the U. S. Children's Bureau, this department, through Children's Hospital of Los Angeles, will now assist families of phenylketonuric infants who cannot afford the added cost of obtaining this special diet.

Twenty-six health departments in California are now participating in a phenylketonuria detection program, the first large-scale attempt in this country to screen well babies for phenylketonuria. Being used is a simple, inexpensive diaper test for early detection. This consists of placing a drop of 10 per cent aqueous ferric chloride on an infant's wet diaper. The appearance of a dark-green color may indicate that the baby has phenylketonuria.

The diet will be available only to children under the age of three years at the time of beginning the diet, under the care of a qualified physician, with a diagnosis of phenylketonuria confirmed by serum phenylalanine determinations, and approved by a special review committee.

Applications should be made in writing to the study project director: Dr. Richard Koch, director, Child Development Clinic, Children's Hospital, 4614 Sunset Boulevard, Los Angeles 27.

Committees

THE PRIVILEGE of membership in the Woman's Auxiliary to your local county medical society inherently involves and invokes many obligations. High on the list of these is the obligation of active committee work.

I cannot emphasize too strongly the important role which committees play in the success of your local county auxiliary. It matters little whether these committees are standing or special committees. Each one of these has its particular important function to perform. Therefore, the county officers should give thought and consideration to the careful selection of committee chairmen and members, to the end that they will accomplish their assigned tasks.

To the President of the Auxiliary falls the responsibility of not only selecting her committee chairmen and members wisely, but also of assigning to these committees the purposes and functions of their particular committees. While generally speaking these activities are well outlined in the by-laws of the county societies, occasions will arise when special committees are formed, and the President must indicate the duties of that particular committee.

To be effective and productive, a committee must be well attended and supported. Active attendance and participation are the keynotes of a successful committee. Failure to attend committee meetings indicates a lack of desire and a lack of responsibility to the Auxiliary. In case of continued absenteeism, replacements should be made. It would be advisable for the committee chairman to appoint a committee member to serve as secretary to keep minutes and to transmit these minutes to the executive board. All committee reports should be written (in the third person) so that a permanent record may be kept. They should contain information and/or recommendations to the Board of Directors of the Auxiliary. Committees have only the power assigned to them by the organization. The minutes of the committee meetings will serve not only as an important liaison between the committee and the executive board, but will also better clarify the reasons for the committee's decisions. In addition, these minutes will be useful as an important guide in the preparation of required annual reports.

The success of a county auxiliary is measured in large part by the accomplishments of its committees. Clearly, the major burden of the many, many activities of our auxiliaries must fall upon the committee's shoulders. The many projects encompassed by these committees literally range from *A* (A.M.E.F.) to *S* (Safety). They cover all the phases requested of us by our parent organization —the California Medical Association. The importance of these committees cannot be overemphasized. I know it is the desire of every county president that each committee member will give of her time and effort diligently, conscientiously and enthusiastically in the furtherance of her Auxiliary. Enthusiasm is contagious. To every committee chairman, I say, make enthusiasm for Auxiliary a habit.

MRS. SAMUEL GENDEL
President, Woman's Auxiliary to the California Medical Association

NEWS & NOTES

NATIONAL · STATE · COUNTY

ALAMEDA

The East Bay Pediatric Society, formed in November of 1959 "for the purpose of uniting the Pediatricians of Alameda and Contra Costa counties in working for the health and welfare of all children," has elected Dr. Edward F. Carlson president and Dr. Marianne Schour secretary.

* * *

A research fellowship to be underwritten by the medical staff of **Children's Hospital of the East Bay** was announced recently. Residents at Children's Hospital of the East Bay, as well as scientists from all over the world, will qualify for this program in future years. They will be selected by the medical staff research committee, which is headed by Dr. Charles L. Dimmler, Jr.

The medical staff is financing this fellowship through medical staff dues plus voluntary contributions of $10 per year from members of the staff. Contributions from other interested persons will be invited.

LOS ANGELES

The Division of Cardiology, Department of Pediatrics, University of California at Los Angeles, announces the establishment of **a training program in pediatric cardiology.** This will include instruction in all of the various aspects of both clinical and basic science pertinent to the practice and teaching of pediatric cardiology. The program is primarily designed for those interested in a career in academic medicine or for those who will be engaged primarily in the practice of clinical cardiology.

Graduates of Class A medical schools who have completed pediatric training acceptable for certification by the American Board of Pediatrics are eligible. Stipends begin at $5,500 per year with additional allowance for dependents.

Further information may be obtained from Dr. Arthur J. Moss, Department of Pediatrics, University of California at Los Angeles, Los Angeles 24.

* * *

Dr. George E. Judd of Los Angeles was elected first vice-president of the American College of Obstetricians and Gynecologists at the organization's annual meeting which was held in Cincinnati last month.

* * *

The Metropolitan Dermatological Society of Los Angeles has announced election of the following officers for the current year: President, Dr. Max Popper; vice-president, Dr. Murray Zimmerman; secretary-treasurer, Dr. Rose B. Saperstein; program chairman, Dr. John Carney.

* * *

A new $1,000,000 **rehabilitation center** has been opened at Cedars of Lebanon Hospital, Los Angeles. It is said to be one of the most modern and comprehensive facilities in the West for treating disabling diseases and accidents. It has a capacity of 250 patients per day, triple the former daily patient average.

Dr. Harry R. Brickman, formerly director of the Psychiatric Clinic, U.C.L.A. Medical Center, has been appointed director of the newly formed Los Angeles County Department of Mental Health.

This department, created by the Board of Supervisors with the approval of the Los Angeles County Medical Association, is charged with responsibilities for coordinating and further developing the community mental health program in Los Angeles County under provisions of the Short-Doyle act.

SAN FRANCISCO

The first joint annual convention of the **American Association of Bioanalysts** and the **California Association of Clinical Laboratories** will be held June 2, 3 and 4 in the new Jack Tar Hotel in San Francisco. Laboratory directors from all over the nation will meet to discuss new methods of bioanalysis and clinical laboratory techniques.

GENERAL

The Second Annual Oregon Cancer Conference will be held July 7 and 8 in Portland under the joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, and the University of Oregon Medical School.

The list of guest lecturers for the conference includes Dr. Oscar Creech, Jr., of New Orleans, professor and chairman of the department of surgery at Tulane University School of Medicine; Dr. J. Hartwell Harrison of Boston, clinical professor of genito-urinary surgery at Harvard Medical School; Dr. Henry Jaffe of Los Angeles, director, division of radiation therapy and nuclear medicine at Cedars of Lebanon Hospital; Dr. I. S. Ravdin of Philadelphia, professor of surgery at the University of Pennsylvania Medical School; and Dr. R. Wayne Rundles of Durham, North Carolina, of the department of medicine at Duke University Medical Center.

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The American Academy of General Practice has joined the **National Health Council,** bringing Council membership to 71 organizations. The Academy has a membership of more than 26,000 physicians in the general practice of medicine and surgery.

The National Health Council, which is made up of the principal voluntary, professional and governmental health agencies and selected business and civic groups concerned with health improvement, provides a mechanism through which member agencies can work together to promote individual and community health.

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The Editors of Modern Medical Monographs announce the 1960 **competition for unpublished manuscripts** on clinical subjects in the field of internal medicine. The purpose of these annual awards, which are known as the Modern Medical Monographs Awards, is to stimulate young physicians to communicate their work in the classical form of the monograph and to achieve high standards of medical writing.

The first prize is $500. In addition, the authors of other top-ranking manuscripts which are found suitable will be offered a contract for publication of their work as a book in the series Modern Medical Monographs under standard royalty arrangements.

Rules governing the competition are:

1. The author must be a graduate physician less than 40 years of age.

2. Manuscripts (including illustrations, if any) should be submitted in duplicate (original and one copy) by registered mail, postmarked no later than December 1, 1960, to

Irving S. Wright, M.D., 450 East 69th Street, New York 21, New York.

3. The manuscript, including the bibliography, must consist of not fewer than 130 or more than 200 double-spaced typewritten pages with one-inch margins, and not more than 30 illustrations (pictorial charts, drawings, diagrams or photographs).

4. Fishbein's book, "Medical Writing" (third edition), should be followed in preparation of the manuscript, use of abbreviations, etc., and bibliographic form.

POSTGRADUATE EDUCATION NOTICES

THIS BULLETIN of the dates of postgraduate education programs and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to: Mrs. Margaret H. Griffith, Director, Postgraduate Activities, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Clinical Traineeships — Anesthesia, Dermatology and Pediatric Cardiology. Dates by arrangement. Minimum period—two weeks. Fee: Two weeks, $150.00; four weeks, $250.00.

SURGICAL ANATOMY. Saturday through Tuesday, June 4 through 7.

Head and Neck. Saturday, June 4. Seven hours. Fee: $40.00.

Thorax, Abdomen and Pelvis. Sunday and Monday, June 5 and 6. Fourteen hours. Fee: $80.00.

Extremities. Tuesday, June 7. Seven hours. Fee: $40.00.

General Pediatrics. Sunday through Wednesday, July 17 through 20. Lake Arrowhead, University of California Residential Conference Center. Sixteen hours. Fee: $137.50 (including room and meals).

Advance Seminar in Internal Medicine. Wednesday through Sunday, July 20 through 24. University of California Residential Conference Center, Lake Arrowhead. Eighteen hours. Fee: $150.00 (including room and meals).

Dermatologic Therapy. Monday and Tuesday, July 25 and 26. Twelve hours. Fee: $40.00.

Advanced Seminars in Dermatology (for Dermatologists). Wednesday through Sunday, July 27 through 31. University of California Residential Conference Center, Lake Arrowhead. Fourteen and one-half hours. Fee: $150.00 (including room and meals).

Anesthesia for Special Procedures. Wednesday, Thursday and Friday, August 3, 4 and 5. Eighteen hours. Fee: $60.00.

Arthritis and Rheumatism. Wednesday and Thursday, August 17 and 18. Twelve hours.*

Obstetrical Procedures and Complications. Thursday and Friday, August 26 and 27. Twelve hours. Fee: $50.00 (includes two luncheons).

*Fees to be announced.

For Ancillary Personnel

Fifth Regional Conference for Nurses. Sunday through Wednesday, June 12 through 15. Thirty-two hours. Fee: $80.00.

The College Nurse: New Concepts in Her Profession. Friday and Saturday, June 17 and 18. Sixteen hours. Fee: $20.00.

9th Annual Symposium in Clinical Laboratory Technology. Saturday and Sunday, June 18 and 19. Sixteen hours. Fee: $20.00.

Workshops for School Nurses:

Riverside, Tuesday through Saturday, June 21 through 25. Forty-five hours. Fee: $40.00.

Los Angeles, Tuesday through Saturday, July 5 through 9. Forty-five hours. Fee: $40.00.

San Diego, Wednesday through Sunday, July 13 through 17. Forty-five hours. Fee: $40.00.

Contact: Thomas H. Sternberg, M.D., assistant dean for Continuing Medical Education, U.C.L.A. Medical Center, Los Angeles 24. BRadshaw 2-8911, Ext. 7114.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Proctology. Thursday and Friday, May 19 and 20. Fourteen hours. Fee: $40.00.

A Course on the Foot. Thursday to Saturday, June 9 to 11. Twenty-one hours. Fee: $50.00.

Obstetrics and Gynecology. Thursday to Saturday, September 15 to 17. Twenty-one hours.*

Surgery, Franklin Hospital. Saturday and Sunday, October 8 and 9. Fourteen hours.*

Dermatology. Friday and Saturday. October 14 and 15. Fourteen hours.*

Fundamental Practices of Radioactivity and the Diagnostic and Therapeutic Uses of Radioisotopes. Two or three month course limited to one enrollee per month. Fee: $350.00.

For Ancillary Personnel

Human Relations in the Modern Hospital. Monday through Friday, June 13 through 17. Fee: $50.00.

Integration of Psychiatric Principles in the Total Curriculum. Tuesday to Friday, July 5 to August 12. Fee: $100.00.

Cancer Nursing. Wednesday through Friday, August 10 through 12.*

Continuing Education Conference Series. Tuesday through Friday, September 6 through 16.*

Administration of Nursing Care. Tuesdays, September 13 through December 13. Fee: $45.00.

Nutritional Aspects of Nursing Care. September 21 through November 9.*

Contact: Seymour M. Farber, M.D., assistant dean, Department of Continuing Medical Education, University of California Medical Center, San Francisco 22. MOntrose 4-3600, Ext. 665.

STANFORD UNIVERSITY SCHOOL OF MEDICINE, PALO ALTO

Emotional and Social Aspects of Child Health in Pediatric Practice. June 13 through 24. *Contact:* Hale F. Shirley, M.D., Professor of Pediatrics and Psychiatry, Stanford Medical Center, 300 Pasteur Drive, Palo Alto, Calif.

STANFORD HOSPITAL, SAN FRANCISCO
(Lane Presbyterian Medical Center)

Eye Conference. Each Monday morning.

Didactic Course in Ophthalmology. Monday and Wednesday, 7 to 8:30 p.m.

Course on Keratoplasty for Specialists in Ophthalmology. Wednesday through Friday, May 18 through 20.

Vector-Electrocardiography. Saturday, May 28.

Postgraduate Conference in Strabismus. Wednesday through Friday, July 13 through 15. Fee: $75.00.

Postgraduate Conference, Retinal Detachment. Wednesday, Thursday and Friday, September 14, 15 and 16.

Contact: Arthur Selzer, M.D., program committee chairman, San Francisco-Stanford Hospital, Clay and Webster Sts., San Francisco 15.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

Cardiac Resuscitation. Sponsored by the Los Angeles County Heart Association each Wednesday throughout the year, 4 to 6 p.m. USC Medical Research Building, Room 211, 2025 Zonal Avenue. Residents and interns of Los Angeles County, and all armed forces medical personnel admitted without fee. Tuition for all other physicians: $30.00. (Each session all-inclusive.)

Basic Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Physicians may register at any time and receive all 52 issues. Fifty-two weeks. Fee: $100.00.

Advance Home Course in Electrocardiography. One year postgraduate series, electrocardiogram interpretation by mail. Fifty-two issues: $85.00. Physicians may register at any time.

Hawaii Course: The USC School of Medicine will offer the Third Postgraduate Refresher Course to be held in Honolulu and on board the S.S. *Lurline* from August 4 to August 20, 1960. (As a time and money saver, round trip air travel is also possible August 4 to August 14.)

Contact: Phil R. Manning, M.D., associate dean and director, Postgraduate Division, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33. CApital 5-1511.

COLLEGE OF MEDICAL EVANGELISTS

CLINICAL TRAINEESHIPS available in all clinical departments by arrangement with the Postgraduate Division and the chairman of the department or departments involved. Eighty hours minimum. Fee: As arranged.

Diseases of the Chest: Two and four-week Traineeships in cooperation with the Los Angeles County Hospital. Dates as arranged.

Anesthesia. Monday through Friday. Dates as arranged. Six months. Fee: $350.

JOINT MANIPULATION. Monday through Friday, 8:00 to 12:00, dates to be arranged. Twenty hours. Fee: $75.00.

For information contact: G. E. Norwood, M.D., assistant dean and chairman, Division of Postgraduate Medicine, College of Medical Evangelists, 1720 Brooklyn Ave., Los Angeles 33. ANgelus 9-7241, Ext. 214.

CALIFORNIA MEDICAL ASSOCIATION

POSTGRADUATE INSTITUTE—1960
(Tenth Anniversary Year)

Sacramento Valley Counties in cooperation with UCLA School of Medicine, July 1 and 2. Tahoe Tavern, Lake Tahoe. *Chairman:* Herbert W. Korngold, M.D., 1217 30th Street, Sacramento.

Contact: The chairmen listed above, or Postgraduate Activities Office, California Medical Association, 2975 Wilshire Boulevard, Los Angeles 5.

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AUDIO-DIGEST FOUNDATION, a nonprofit subsidiary of the C.M.A., offers (on a subscription basis) a series of six different hour-long tape recordings covering general practice, surgery, internal medicine, obstetrics and gynecology, pediatrics and anesthesiology. Designed to keep physicians posted on what is new and important in their respective fields, these programs survey current national and international literature of interest and contain selected highlights of on-the-spot recordings of national scientific meetings, panel discussions, symposia, and individual lectures. For information contact Mr. Claron L. Oakley, Editor, 1919 Wilshire Blvd., Los Angeles 57, HUbbard 3-3451.

Medical Dates Bulletin

MAY MEETINGS

NATIONAL TUBERCULOSIS ASSOCIATION—AMERICAN TRUDEAU SOCIETY Annual Meeting. May 16 through 19. Statler Hilton and Biltmore Hotels, Los Angeles. *Contact:* Mr. Sherman Asche, general chairman, Annual Meeting Committee, P. O. Box 4037, Santa Barbara.

AMERICAN COLLEGE OF NUTRITION 1960 Annual Convention. May 20 through 22. Huntington Sheraton Hotel, Pasadena. *Contact:* Donald B. Haynie, executive secretary, 10651 West Pico Blvd., Los Angeles 64.

CALIFORNIA HEART ASSOCIATION Annual Meeting and Scientific Session. May 20 through 22. Claremont Hotel, Berkeley. *Contact:* J. Keith Thwaites, executive director, 1428 Bush Street, San Francisco 9.

GROUP PSYCHOTHERAPY ASSOCIATION OF SOUTHERN CALIFORNIA 7th Annual Conference. Saturday, May 21. Chapman Park Hotel, Los Angeles. *Contact:* A. R. Abarbanel, M.D., chairman, 435 N. Bedford Drive, Beverly Hills.

LONG BEACH SURGICAL SOCIETY Annual "Clinic Day." May 21. Lafayette Hotel, Long Beach. 2 p.m. to 9 p.m. *Contact:* Harriman Jones, M.D., secretary-treasurer, 211 Cherry Ave., Long Beach 2.

JUNE MEETINGS

CHILDREN'S HOSPITAL OF THE EAST BAY "The Clifford Sweet Seminar." June 2, 3 and 4. Claremont Hotel, Berkeley. *Contact:* James L. Dennis, M.D., medical director, Children's Hospital of the East Bay, 51st at Grove, Oakland 9.

AMERICAN ASSOCIATION OF BIOANALYSTS and CALIFORNIA ASSOCIATION OF CLINICAL LABORATORIES Joint Convention, June 2, 3 and 4, Jack Tar Hotel, San Francisco. *Contact:* William Reich, convention manager, Lafayette Laboratory, 1409 Nursery Lane, Walnut Creek.

San Francisco Psychoanalytic Institute one-day workshop on Problems of Childhood and Adolescence. June 5. Guest speakers: Dr. Anneliese F. Korner of Hampstead Child-Therapy Clinic, London, England, and Dr. Fritz Redl, Stanford Center for Advanced Study in the Behavioral Sciences. Mark Hopkins Hotel, San Francisco. Fee: $10.00. *Contact:* Miss Jennie Chiado, executive secretary, San Francisco Psychoanalytic Institute, 2380 Sutter Street, San Francisco 15. WEst 1-4205.

San Diego County Medical Society and the Medical Department, 11th Naval District. Symposium on Clinical Medicine and Surgery. Sunday, June 5, 8:30 a.m. to 5:00 p.m. El Cortez Hotel, San Diego. *Contact:* Michael J. Feeney, M.D., program chairman, 3427 Fourth Ave., San Diego 3.

AUGUST MEETINGS

Gerontological Society, Inc., Mark Hopkins Hotel, San Francisco. August 7 through 12. *Contact:* Mrs. Marjorie Adler, administrative secretary, 660 S. Kingshighway Blvd., St. Louis 10.

Reno Surgical Society 10th Annual Conference. August 18, 19 and 20. The Mapes Hotel, Reno. *Contact:* Harry B. Gilbert, M.D., 275 Hill Street, Reno, Nevada.

American Association of Blood Banks, Jack Tar Hotel, San Francisco. August 21 through 26. *Contact:* John B. Alsever, M.D., secretary, 1211 W. Washington St., Phoenix, Arizona.

American Hospital Association, Civic Auditorium, San Francisco. August 27 through September 1. *Contact:* Mr. Maurice J. Norby, assistant director, 18 E. Division St., Chicago.

SEPTEMBER MEETINGS

Pacific Dermatologic Association Inc. 12th Annual Meeting. Empress Hotel, Victoria, British Columbia. September 2 through 4. *Contact:* Edward Ringrose, M.D., secretary, 2636 Telegraph Ave., Berkeley.

Oregon State Medical Society, Portland. September 7 through 9. *Contact:* Mr. Roscoe K. Miller, executive secretary, 1115 S. W. Taylor St., Portland 5, Oregon.

Nevada State Medical Association Annual Meeting. September 7 through 10. Stardust Hotel, Las Vegas. *Contact:* Nelson B. Neff, executive secretary, P. O. Box 2790, Reno, Nevada.

Postgraduate Assembly of Saint John's Hospital. September 8 through 10. 9 a.m. to 4 p.m., St. John's Hospital, Santa Monica. *Contact:* John C. Eagan, M.D., director, 1328 22nd St., Santa Monica.

Santa Barbara County Heart Association Physicians Symposium. September 17, 9:00 a.m. to 5:00 p.m., Biltmore Hotel, Santa Barbara. *Contact:* E. J. Hannon, executive director, 18 La Arcada Court, Santa Barbara.

California Society of Internal Medicine Annual Meeting, Yosemite. September 23, 24 and 25. *Contact:* Barbara E. Oulton, executive secretary, 350 Post St., San Francisco 8.

Washington State Medical Association Annual Convention. September 25 through 28. Olympic Hotel, Seattle, Washington. *Contact:* R. W. Neill, executive secretary, 1309 7th Avenue, Seattle, Washington.

Pan-Pacific Surgical Association 8th Intensive Surgical Congress, embracing all Surgical Specialties. September 28 through October 5. Honolulu, Hawaii. *Contact:* F. J. Pinkerton, M.D., director general, Suite 230, Alexander Young Building, Honolulu 13.

OCTOBER MEETINGS

American Society of Plastic and Reconstructive Surgery. Statler Hotel, Los Angeles, October 2 through 7. *Contact:* Thomas R. Broadbent, M.D., secretary, 508 E. S. Temple, Salt Lake City.

San Diego County Heart Association 10th Annual Symposium on Heart Disease. October 3 and 4. El Cortez Hotel. *Contact:* O. Martin Avison, 3545 Fourth Avenue, San Diego 3.

American Association for the Surgery of Trauma. Coronado Hotel, San Diego. October 5 through 7. *Contact:* William T. Fitts, Jr., M.D., secretary, 3400 Spruce St., Philadelphia 4.

Los Angeles County Heart Association 30th Annual Professional Symposium on Cardiovascular Diseases. October 5 and 6. Beverly Hilton Hotel, Beverly Hills. *Contact:* Los Angeles County Heart Association, 2405 W. 8th St., Los Angeles 57.

San Francisco Heart Association 30th Annual Postgraduate Symposium on Heart Disease. October 5 through 7. St. Francis Hotel, San Francisco. *Contact:* Mr. Lawrence I. Kramer, Jr., executive director, 259 Geary St., San Francisco 2.

Western Industrial Medical Association combined Meeting with 4th Western Industrial Health Conference. October 7 through 9. Jack Tar Hotel, San Francisco. *Contact:* Verne G. Ghormley, M.D., president, 3032 Tulare Street, Fresno 21.

American College of Surgeons, 46th Annual Clinical Congress, San Francisco. October 10 to 14. *Contact:* William E. Adams, M.D., secretary, 40 E. Erie St., Chicago 11.

American Cancer Society California Division Annual Meeting. October 13 through 15. Villa Hotel, San Mateo. *Contact:* Jane N. Lounsbury, assistant director, Field Services, 467 O'Farrell, San Francisco.

Kaiser Foundation Hospitals in Northern California Fourth Annual Symposium on Human Genetics. October 14 and 15. Fairmont Hotel, San Francisco. *Contact:* Martin A. Shearn, M.D., Director of Medical Education, 280 West MacArthur Blvd., Oakland.

California Academy of General Practice 12th Annual Scientific Assembly. October 16 through 19. Masonic Memorial Temple, San Francisco. *Contact:* William W. Rogers, executive secretary, 461 Market St., San Francisco 5.

Western Orthopedic Association Annual Convention. October 22 through 27. Hotel Del Coronado, Coronado. *Contact:* Mrs. Vi Mathieson, executive secretary, 354 21st St., Oakland 12.

St. Jude Hospital—Fullerton 2nd Annual Postgraduate Assembly. October 27 and 28. St. Jude Hospital. *Contact:* B. L. Tesman, M.D., chairman, St. Jude Hospital, Fullerton.

American School Health Association, San Francisco. October 30 through November 4. *Contact:* A. O. DeWeese, M.D., executive secretary, 515 E. Main St., Kent, Ohio.

American Public Health Association, San Francisco. October 31 through November 4. *Contact:* Berwyn F. Mattison, M.D., executive director, 1790 Broadway, New York 19.

THE PHYSICIAN'S *Bookshelf*

TECHNIC AND PRACTICE OF PSYCHOANALYSIS—Leon J. Saul, M.D., Professor of Clinical Psychiatry, Medical School of the University of Pennsylvania; Training Analyst, Philadelphia Psychoanalytic Institute; Psychiatric Consultant, Swarthmore College. J. B. Lippincott Company, Philadelphia, Pennsylvania, 1958. 244 pages, $8.00.

Dr. Saul's book is divided into two parts. The first and much the shorter part is headed "Approach," with a subhead "What is to be accomplished." In this part of the book the author discusses the nature and the goals of psychoanalytic treatment, together with a discussion of the attitudes of the analyst and a discussion of the basic theory of psychoanalysis. Dr. Saul has included a great deal of information in this section with which most psychoanalysts would agree. There are, however, certain statements with which many analysts would disagree. For example, some analysts are of the opinion that the works of Freud should be studied chronologically, which Dr. Saul evidently considers unwise.

In other parts of this section some of the illustrative material is presented in a way which raises a question as to whom Dr. Saul has addressed his book. This question will be discussed in more detail later in the review.

The second part of the book is titled "Practice, How to Accomplish Therapeutic Goals." In this section the author has included essays on several aspects of psychoanalytic technique, beginning with a discussion of the first interviews. There follows then a description and discussion of free association, the understanding of unconscious material and a chapter on dreams. He continues to include material concerning the conducting of the analysis, interpretations and other pertinent material. He concludes with a section on special problems, with illustrations of difficulties and failures in psychoanalysis. Finally, he discusses progress and termination of the analysis.

In his discussion of each of these subjects Dr. Saul states his position clearly, together with supporting reasons. In some instances his formulations probably would be accepted by most analysts, but there are exceptions. For example, he advises that in the initial interview the attempt be made to obtain specific anamnestic material, together with information concerning social factors in the life of the patient. Along with this, he points out the necessity for paying close attention to the associative material and the value of early formulation of the patient's principal difficulties. This reviewer agrees with the author's approach, but there are many analysts who do not.

From the title of the book it would appear obvious that the book is intended for students of psychoanalysis. This would include both students who are in training and those who are in practice. There is, I believe, some question as to how many teachers in psychoanalytic institutes will recommend the book for students in training. For psychoanalysts in practice the book is of interest because the material with which the author deals is of greatest importance. It is unlikely that most analysts in practice would agree completely with Dr. Saul's presentation.

The publication of this book raises an old question concerning the attempt by inadequately trained people to use technical information. It appears that many untrained individuals are willing to try to apply technical measures in the field of mental and emotional disorders who would not consider, for example, attempting intricate brain surgery without special training. While it is true that possible bad results would not be the same in both cases, there is a great deal of evidence that much harm and useless suffering are produced when such ill advised attempts are made.

The book then will be principally of value to students of psychoanalysis. It may also be useful as a source of general information to interested people in other fields.

CHARLES W. TIDD, M.D.

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THE MIDDLE EAR—Heinrich G. Kobrak; foreword by John R. Lindsay. The University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois, 1959. 254 pages, $15.00.

The remarkable, recent advances in preservation or improvement of hearing through surgery of the middle ear have created a need for a book such as Kobrak's. These new surgical methods require a considerable knowledge of anatomy, physiology and bio-acoustics; such information is available in Part I, in more complete detail, than in any book published to date.

Most of the otologists in this country are well aware of the late Dr. Kobrak's development of the motion picture camera as a tool for teaching and demonstrations as well as for research. He has used these skills in photography to illustrate sections on anatomy and physiology.

The important role that a knowledge of physiology plays in current reconstructive ear surgery is reflected in the fifty-four pages devoted to it. Though it is highly technical in some instances, it is presented in an easy-reading style and is most informative.

The chapter on testing is as modern as the rest of the book, but is limited to the audiometric characteristics of middle ear deafness. Considerable detail is given to the measurement and significance of bone conduction.

Part II is devoted to treatment. Men prominent in otology are the contributors—Lindsay on "Otosclerosis and Fenestration"; Rosen on "Mobilization of the Stapes"; Kobrak on "Treatment of Middle Ear Deafness by Prosthesis"; Wullstein on "Tympanoplasty, Audiology Indications, Technique and Results"; and Zoellner on "Plastic Surgery of the Sound-Conduction System of the Middle Ear." The one important person not included in this renaissance of ear surgery is Lempert, though his significant contributions have been adequately referred to by Lindsay.

There are 240 black-and-white illustrations and six color plates. The reference list is excellent.

This book is in a class by itself and should find its way into the library of every dedicated otolaryngologist.

SHIRLEY HAROLD BARON, M.D.

THE GOLDEN SCALPEL—Seymour Kern. The John Day Company, Inc., 210 Madison Ave., New York, N. Y., 1960. 248 pages, $3.50.

This novel pictures the physicians in Beverly Hills as doctors who look upon the practice of medicine as a short cut to wealth rather than a way of life and, incidentally, when they are not undermining each other they have habits like rabbits.

The story moves quickly with an undistinguished style and in fact even with minor grammatical errors but will undoubtedly appeal to those who still cling to the cloak and dagger approach of Bernard Shaw regarding malpractice. It is unfortunate that the author did not take the trouble to research the matter or question some knowledgeable doctor to become informed of the constructive steps taken locally in the very area of malpractice he describes.

For example, the statement is made that one doctor due to the connections of his brother, an influential politician, was one of the few who enjoyed staff membership in most of the hospitals in the city. Actually most doctors don't want membership on too many hospital staffs but it is well known that courtesy privileges are easily obtained in all hospitals by competent physicians and the closed shop exists to a very minor degree.

The cast of characters is almost as simple as a soap opera on radio or television with the good doctors wearing the white pants and the bad doctors the black pants. It would appear that the doctor leaning toward the left who is in favor of socialized medicine or who goes to work for a group or a clinic suddenly is transformed into a very good and competent doctor, whereas the solo practitioner is motivated by greed rather than the welfare of the patient and, therefore, is an incompetent doctor.

We are expected to accept as fact that doctors are capitalizing on an alleged shortage of doctors and yet on the other hand the jungle of cutthroat competition in the area described is such that the doctors involved spend much of their time undermining each other because there are too many doctors in the area.

The high point is the description of a vaginal hysterectomy —someone who has done one should have proofread this description—on a patient who is pregnant (whose problem actually had been an inability to become pregnant) and a point is made that the showmanship of the surgeon in doing it is such that he does a vaginal hysterectomy when an abdominal hysterectomy would have prevented removing the pregnant uterus.

The crazed husband shoots the surgeon in the abdomen and the surgeon is taken to the hospital but operated on, with his wife's consent, by an incompetent rather than by his friend in the white pants, since his friend has been tossed off the staff of the hospital because of his liberal leanings. Subsequently he presumably dies of postoperative hemorrhage while his friend who could have saved him stands by in his tweed suit presumably not having guts enough to take over from the incompetent surgeon.

Other facets brought out in the novel deserve some comment. Bland stipulation or acceptance of generalized anti-Semitism will come as a surprise to the physicians in Los Angeles who know that it is practically nonexistent here.

No one with integrity would ignore evils inherent in some proprietary hospitals and staffs who seem more preoccupied with their own financial welfare than the care of the patient.

It's easier, however, to throw rocks at the window and then run for the bushes than to tell the whole story.

There are hospitals which exist for the welfare of the patient and are staffed by men of integrity devoted to the pursuit of excellence in the care of patients and in research as well.

Recently a general practitioner from Brea, California, was buried. He was not the old time family doctor who worked hard but died a pauper and had the whole town turn out for his funeral. He was an intelligent and dedicated practitioner who achieved reasonable wealth incident to taking good care of his patients. He was a man with a three hundred horsepower motor in a twenty horsepower chassis and gave much of himself to good causes in the field of medicine as well as in civic enterprises. He worked for his friends in the political field and was active in organized medicine as well. He did not have to buy good public relations; he deserved them. He numbered among his friends senators and vice-presidents as well as common men. Medicine to him was not a way to wealth but a way of life. The day of his funeral all the stores in Brea closed.

This book will undoubtedly appeal to the group preoccupied with undermining the medical profession. I would predict, however, that the book will produce a smaller splash than others of its type about the doctor business.

WM. F. QUINN, M.D.

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KINESIOLOGY AND APPLIED ANATOMY—The Science of Human Movement—Philip J. Rasch, Ph.D., C.C.T., F.A.C.S.M., Associate Professor of Physical Medicine and Rehabilitation, College of Osteopathic Physicians and Surgeons, Los Angeles, California. Roger K. Burke, Ph.D., F.A.C.S.M., Associate Professor of Physical Education, Occidental College, Los Angeles, California. Lea & Febiger, Philadelphia, 1959. 456 pages, $7.50.

The science of kinesiology, the knowledge of movements involving function of muscle, and physiology of joint systems are of unquestioned importance to medical personnel. In treating this subject it has always been most difficult to capture the imagination and interest of the reader. The authors, however, have succeeded in formulating a most attractive and interesting, yet complete, treatment of this difficult subject. It is written for surgeons, physiatrists, physical and occupational therapists, and teachers of physical education who wish better to understand some of the fundamental principles of muscle and joint systems.

A valuable history of the subject is first given with reference to such traditional authorities as Galvani, Duchenne, Borelli, Weber, Braune, Fischer, R. Fick, Sherrington, and Darwin. The enormous contributions of these individuals and others to the field of kinesiology is described. Each chapter is followed by a very complete bibliography.

A chapter entitled, "The Structure and Action of Striated Muscle" is very skillfully handled. The histology, neuroanatomy and electrophysiology of muscle are presented. Modes of muscular activity demonstrated by the electromyogram are described.

Many purely mechanical and physical considerations, such as the acceleration of the body due to gravity and other forces are explained. A section on kinematics describes the effects of rotary motion. Newton's laws of motion, power, and other physical considerations are explained.

Motions of the body and its parts are then described in terms of the center of gravity and leverage systems about the body.

Of interest to coaches and teachers of physical education are sections on posture and the application of kinesiology in athletics.

The book does a great deal to provide a basic explanation for the way in which the body uses its muscles, leverage systems and joint systems to accomplish certain tasks, or movements. Knowledge of such principles is essential to those engaged in reconstructive and rehabilitative work on the musculoskeletal system.

The book is well illustrated throughout.

J. ROBERT CLOSE, M.D.

MICROBIAL VARIATION—Edited by V. D. Timakov, member of the Academy of Medical Sciences of the U.S.S.R. Translated from the Russian by G. H. Beale. Pergamon Press, Inc., 122 East 55th Street, New York 22, N. Y. 202 pages, $6.50.

The purpose behind the immense effort involved in the translation of this book is not at all clear to this reviewer. The major fraction of the material presented is a confused mixture of dialectical materialism, pseudoscience, and Soviet genetics of the Lysenko variety. It must be admitted that many of the thoughts and opinions expressed in this work have at one time or another been held by microbiologists in other countries, but have now been quite uniformly discarded.

Not all of the material presented is worthless, however. For instance, the data presented in the arguments concerning losses of virulence appearing conjointly with the development of (induced) antimicrobial resistance are similar to results achieved in other parts of the world. It is regrettable that in these sections, however, as well as in the rest of the presentation the references are almost exclusively to the Soviet literature. This is understandable for the major fraction of the material cited above, but seems a significant omission when considered for the sections dealing with induced changes in virulence alone.

In short, this book would seem worthwhile for the microbiologist interested in an exhaustive treatise on current Soviet thought and research on directed microbial variation with its implications for the development of strains of diminished virulence for vaccines, or strains of increased virulence for less peaceful uses. For the uninformed reader who wishes to become better acquainted with this subject, this reviewer would suggest that he delay reading this work until he acquires a grounding in the truly scientific aspects of microbial variation.

HAROLD J. SIMON, M.D.

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CLINICAL PSYCHOPATHOLOGY — Kurt Schneider, Professor, University of Heidelberg, Germany. Translated by M. W. Hamilton, B.A. (Lit. Hum.) Oxon., University of Manchester, Dept. of Psychiatry, The Royal Infirmary, Manchester, England. Preface by E. W. Anderson, M.D., M.Sc., F.R.C.P., D.P.M., Professor, University of Manchester, Dept. of Psychiatry, The Royal Infirmary, Manchester, England. Grune & Stratton, Inc., 381 Fourth Avenue, New York 16, N. Y., 1959. 173 pages, $4.50.

This volume is a translation based on the fifth revised edition of the original *Klinische Psychopathologie* by Kurt Schneider, who retired as Professor of Psychiatry at the University of Heidelberg in 1955. The translation has been done by M. W. Hamilton of the Department of Psychiatry, University of Manchester.

A preface to the book has been written by Professor E. W. Anderson, also of the University of Manchester, which serves an exceedingly useful purpose for readers in the United States who, like this reviewer, are not entirely familiar with the details of the development of psychiatry in Germany. Anderson points out that Kurt Schneider has been one of the outstanding figures in European psychiatry for more than 40 years. Schneider's psychiatric thinking comes under the general heading of Kraepelinian tradition, and he was particularly influenced by Karl Jaspers who ". . . laid the foundations of the (so-called) school of 'Phenomenology'." The author of the preface then continues to discuss the phenomenologic approach and shows something of the relationship with other schools of thought.

Upon turning to the content of the book, one notes first that Schneider begins with a classification of clinical material and a definition of illness. It is immediately apparent that his approach is markedly different from that commonly taught and used in the United States. His classification certainly has the advantage of simplicity, since there are only two principal groups. The first includes "Abnormal Variations of Psychic Life." Group two is labelled "Effects of Illness (and Defective Structure)."

In group one he lists three items: Abnormal intellectual endowment, abnormal personality and abnormal psychic reaction. In group two are included the psychoses. Group two is further subdivided to indicate the somatic etiology and the psychic symptomatology. For all of the conditions except psychothymia (manic-depressive psychoses) and schizophrenia the organic etiological basis is indicated. For the two exceptions, psychothymia and schizophrenia, the author has placed question marks to indicate the unknown somatic background.

Schneider makes it very clear that he considers illness to exist only in connection with the presence of morbid organic change. He states that he holds to this in spite of the fact that it has not been confirmed by organic pathological investigations.

The author then continues to discuss the items he has designated in his classification. It is in this main section of the book that the reader is able to see the beautiful skill developed by Schneider in his description of the observable elements in mental illness. Throughout the text there are indirect references to the mechanisms by which these elements, symptoms for example, have been brought about. In several such instances he refers to psychoanalytic concepts.

For one who has been brought up to use the dynamic approach, the book appears to have little to offer beyond a demonstration of careful observation of the signs and symptoms of mental illness. Such a reader misses a framework on which to place the observed data. It is possible that Schneider has such a framework, but if so, this reviewer has not been able to perceive it in this book. One gets the feeling that if it were possible to observe Schneider working with patients, the book would be much more meaningful.

It is difficult for the reviewer to recommend the book other than to psychiatrists who wish to have some understanding of the work of an important European in the field.

CHARLES W. TIDD, M.D.

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PRACTICE OF CLINICAL CHILD PSYCHOLOGY—Alan O. Ross, Ph.D., Chief Psychologist, Pittsburgh Child Guidance Center, and Adjunct Associate Professor of Psychology, University of Pittsburgh, Pittsburgh, Pennsylvania. Grune & Stratton, Inc., 381 Fourth Avenue, New York 16, New York, 1959. 275 pages, $5.75.

At the present time there is still a considerable struggle going on between psychiatrists and psychologists concerning their various roles with the patient. While this struggle is minimal in the child field, this book will serve to express some of the problem. It is a very calm expression of the role of the clinical psychologist working with children and for the most part, by its lucidity, clarifies the differing roles that psychiatrists and psychologists can have. The reader will be grateful for the historical presentation as well as for a definition of various jobs in keeping with the functions needed in a clinical operation.

The most serious criticism to be leveled against the book concerns the minimization of the research role of the psychologist. Those of us in psychiatry who are often dependent on psychologists, and certainly look to them for assistance in defining problems, will feel that Dr. Ross has not spent enough time in considering this aspect. However, there is an excellent description of the testing function of the psychologist and of the various tests which can be employed. The latter should be most helpful to any physician in looking for the kind of results he should expect from a psychologist working with children.

HENRY WORK, M.D.

INTRODUCTION TO COLPOSCOPY—A Diagnostic Aid in Benign and Preclinical Cancerous Lesions of the Cervix Uteri—Karl A. Bolten, M.D., Gynecologist and Research Associate, Dept. of Pathology, Subdivision Obstetric and Gynecologic Pathology, University of Oklahoma, School of Medicine. Cooperating in Pathology, William E. Jaques, M.D., Chairman and Professor of Pathology, University of Oklahoma, School of Medicine; with Forewords by Joe Vincent Meigs, M.D., and Daniel W. Goldman, M.D. Grune & Stratton, Inc., 381 Fourth Avenue, New York 16, N. Y., 1960. 76 pages, $7.75.

This slender volume is an effort to revive interest in a diagnostic procedure which many gynecologists abandoned 25 to 30 years ago, largely because of the difficulty in interpretation of the bizarre patterns seen on the distal end of the cervix. Despite the author's enthusiasm for the colposcope, it seems unlikely that it will prove more helpful than conization of the cytologically positive cervix to detect carcinoma in situ.

However, for those with a desire to know more about the colposcope and how to use it, Bolten's monograph can be recommended. In addition to the technical aspects, there are descriptions of what one may see in the presence of various benign and malignant processes involving the cervix and vagina. Approximately half the book is devoted to illustrations—of the instrument and accessories, copies of drawings from an atlas by Mestwerdt, colored photographs of cervices (mostly contributed by Wespi from Switzerland), and a few histopathologic photomicrographs. There is also a list of 127 references, but this contains many duplications, owing to the unconventional manner in which reference numbers are used throughout the text.

This book is beautifully printed on paper of excellent quality, and for the most part the illustrations are very good. Some of the black and white photomicrographs leave something to be desired, but this appears not to be the fault of the printer. The price seems high for so few pages, but one must presume that illustrations in color are costly.

C. E. McLennan, M.D.

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MOLOY'S EVALUATION OF THE PELVIS IN OBSTETRICS—Second Edition — Charles M. Steer, M.D., Med.Sc.D., F.A.C.S., F.A.C.O.G., Associate Professor of Clinical Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, and the Sloane Hospital for Women. W. B. Saunders Company, Philadelphia, 1959. 131 pages, $4.00.

The second edition of this outstanding monograph has been very well written by Dr. Steer. The anatomy of the pelvis and the classification of the various types of pelves are very clearly and very accurately described. A thorough consideration of the details of the clinical examination of the pelvis is included.

In his discussion of the significance and usefulness of an accurate knowledge of the pelvis Dr. Steer takes a very realistic view. He describes in detail the mechanism of labor and in particular the type of engagement noted in the various types of pelves. He emphasizes, for example, the increase in posterior positions with android and anthropoid pelves. From this he proceeds logically to a discussion of the treatment of pelvic arrest with forceps in the different types of pelves and gives an excellent discussion of the proper forceps maneuvers to be employed.

Dr. Steer states that x-ray pelvimetry should be performed only in those cases in which clinical evidence of disproportion exists and that this will be true in not over 10 per cent of patients. He feels that pelvimetry should be obtained after the onset of labor and describes the technique to be employed. He wisely states that x-ray examination provides only a statistical statement of the probability of serious arrest and that this can then be used as one factor in determining the best method of delivery.

The summary at the end of the last chapter is excellent. Here the author mentions the facts that some patients with high degrees of disproportion do deliver spontaneously and that in some clinics pitocin infusion is being used to overcome disproportion. However, he cites possible dangers to the child under these circumstances. On the other hand, he decries the excessive use of cesarean section when one is not certain that disproportion exists and states that use of x-ray pelvimetry is the only way to be certain.

In this second edition Dr. Steer has amplified the discussion of the use of forceps in overcoming arrest and makes many very helpful and practical suggestions. The number of patients who have been surveyed has been greatly increased during the eight years which have elapsed since the publication of the first edition. This permits a more detailed consideration and more significant conclusion regarding the probability of difficult delivery with a given amount of disproportion.

In my opinion this is an excellent monograph which should be thoroughly perused by all men in training in obstetrics and gynecology. It makes interesting reading too for those of more experience who must critically review periodically their own feelings about the principles of management of the patient having a difficult labor.

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PSYCHIATRY: DESCRIPTIVE AND DYNAMIC—Jackson A. Smith, M.D., F.A.C.P., Clinical Director, Illinois State Psychiatric Institute, Chicago, Illinois. The Williams & Wilkins Company, Baltimore 2, Maryland, 1960. 342 pages, $7.00.

The increasing burden of knowledge of psychological behavior and the application of medical techniques to the field of psychiatry leads to two major issues. One is that of communication of this knowledge to the nonpsychiatric physician, and the other a real difficulty in trying to translate such knowledge into more general terms. This book represents a further attempt to bridge these gaps and to lay out as clearly as possible the findings of psychiatry so that they may be utilized by any practitioner.

The text includes good explanations of the history and the schools of psychiatry, as well as a clear, current exposition of psychodynamics and the psychiatric examination. The bulk of the material of the book is taken up with the various reactions which are seen in current psychiatric practice. It is felt that the author has somewhat more of an emphasis on hysteria and hysterical phenomena than he does on other reactions, but in general there are clear pictures of schizophrenia, of the affective reactions, and certain neurotic pictures. It is felt that there could be an expansion, for the purpose of the book, of the material concerned with the psychophysiological disturbances, since such psychosomatic reactions make up a large bulk of nonpsychiatric practice.

There is, however, a good section on child psychiatry for the general practitioner.

One criticism of this book is found in the rather abrupt manner in which all topics are presented. The writer is extremely forceful, and sometimes his forcefulness leads to an overstatement of dynamic material in comparison to a more conservative approach. There is obvious evidence that the writer is not impressed with many dynamic formulations, and the thinly veiled cynicism with which his ideas are expounded sometimes seems out of place in a general textbook.

With these limitations, however, the material, particularly in certain areas, is good. If, as has been noted, the psychodynamics of the psychosomatic conditions could be expanded, it would become indeed a rather valuable textbook.

Henry H. Work, M.D.

INSTRUCTIONAL COURSE LECTURES—Volume XVI —The American Academy of Orthopaedic Surgeons—Editor, Fred C. Reynolds, M.D., St. Louis, Missouri. The C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, Missouri, 1959. 334 pages, illustrated, $16.00.

The perennial classic again brings to the reader excerpts from the 1959 instructional course lectures of the American Academy of Orthopaedic Surgeons. Although, for practical purposes, all the lectures could not be given, those selected were excellent in content, thorough, and of timely interest.

The first section, a symposium on athletic injuries, ignores the various methods of treatment which have been known and well documented. Emphasis wisely is on diagnosis and on prevention of injuries, both by prophylactic exercise programs and the fitting of the athlete to the sport. Both factors are described in excellent fashion and with numerous tables and sketches for illustration. This symposium alone makes this volume a valuable adjunct to all who see and treat athletes.

The course on the anatomy of the hand and its injuries provides an excellent review, particularly to those who may infrequently need an easily read and short essay on this subject.

A new concept on the pathogenesis of Dupuytren's contracture is offered by Dr. Luck. By dividing the disease into three stages, specific treatment for each stage may be offered. Dr. Luck's large series and results are impressive and worthy of study to all students of the hand.

Dr. Riordan, in one review, brings together the classical procedures for treating of the paralytic hand. In addition, a new technique is offered. This again is a must to all who are exposed to this problem.

The review of the congenital club foot by Dr. McCauley summarizes past developments in this often difficult field. A new concept in medical release is offered, which in detail describes the rather massive release with appropriate and lucid descriptions of pitfalls and their avoidance. Complementing the latter is the procedure by Heyman, et al., on surgical correction of resistant metatarsus varus. The procedure and example are well illustrated and the results impressive.

A most needed contribution is offered by Dr. Heyman, et al., on the subject of congenital convex pes valgus, or the so-called vertical talus. This problem, more common than suspected, is a most difficult one to treat, since conservative measures have consistently failed. The English literature has been sorely lacking in discussion and treatment, and this needed article brings together diagnosis and surgical treatment, with an extensive series to support it.

Dr. Crice reports further on his subtalar arthrodesis. In addition, this article gives a good review of valgus deformities regardless of cause.

In the symposium on knee injuries, and in addition to a review of this problem, Dr. Kaplan's views on the etiology and pathogenesis of discoid menisci deserve this wider distribution and will no doubt upset many a cherished tradition.

In the symposium on the spine, the pressing problem, both medical and economic, of the industrial back is succinctly presented. A sobering thesis, with overtones in many directions in this day of paternal government, is the flat assertion of the relationship of disability and compensation. This essay would be illuminating to many outside of the medical profession.

Dr. Schmidt ably brings his vast experience and knowledge of the treatment of the scoliotic spine in an essay which again should be required reading of all who must care for this problem.

The large series of Young and Love of the Mayo Clinic, comparing excision of the disc with discectomy and fusion, brings this problem again to scrutiny. Their impression of the superiority of the combined procedures appears to be tipping the pendulum away from the swing of discectomy alone.

C. W. Goff reviews the methods of estimating growth of extremities in treatment of unequal extremities. Of interest is the success of some of the less "scientific" method. Electromyelography is presented less as a review and more as a diagnostic tool for orthopedists, who have been slow to use this definitive method of diagnosis in puzzling problems. Of particular note is its value in differentiating primary myopathies from lower motor neuron lesions.

The ever-present divergence of views on the uses of hip prostheses are again raised in the last symposium. It appears that all views are staunchly defended. The reader will most probably find a defense of his own views here and will not be persuaded to change them.

As is true each year, this volume deserves its place on the active shelf of the orthopedist's library. It will also serve ancillary branches of medicine whose interests overlap in any of the described symposia.

MERRILL C. MENSOR, M.D.
JOHN J. DEMAS, M.D.

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MEDIEVAL AND RENAISSANCE MEDICINE—Benjamin Lee Gordon, M.D., F.I.C.S. Philosophical Library, 15 East 40th Street, New York 16, N. Y., 1959. 843 pages, $10.00.

This thick book (some 800 pages), dealing in a general way with medieval and Renaissance medicine, makes remarkably good and instructive reading. After a few introductory chapters to set the stage, the plan of each chapter is to develop a topic in general and to conclude with a series of sketches of individual physicians. Thus the volume is useful as a general history as well as a reference book to particular physicians; it is well documented with references to each chapter. There are an index and numerous illustrations. It is a book which every doctor will find useful and every medical student should read.

ARTHUR L. BLOOMFIELD, M.D.

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RADIOLOGIC EXAMINATION OF THE SMALL INTESTINE—2nd Edition—Ross Golden, M.D., Visiting Professor of Radiology, University of California at Los Angeles; Professor Emeritus of Radiology, Columbia University; formerly, Director of Radiology, The Columbia-Presbyterian Medical Center, New York City. Charles C. Thomas, Publisher, Springfield, Ill., 1959. 560 pages, $28.50.

This monograph is divided into 29 chapters which contain material based largely on the author's extensive experience at the Columbia-Presbyterian Hospital in New York City. The sections on anatomy, embryology and physiology are commendable and should be of use to radiologists and other clinicians. The sections on the normal small intestine, especially that of the infant, are useful but not as thorough as in Caffey's textbook. The succeeding chapters deal with many diverse disorders, the conclusions in some of them being based apparently on the examination of less than half a dozen cases. The differential diagnostic features suffer understandably from the fact that there is no marked specificity to the roentgen findings in many of the different small bowel conditions discussed.

The chapters on peritoneal adhesions and intestinal ileus are useful, but perhaps more thoroughly covered in Frimann-Dahl's monograph.

Amongst the conditions discussed with ability and adequate illustrations are regional enteritis, parasitic infections and neoplasms.

The format of the book is pleasing; the illustrations are of good quality and the references and index adequate.